IN LIEU OF FORM CMS-2552-96(04/2005)
PREPARED 12/ 8/2009 11: 0

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)). FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	PROVIDER NO: 14-1311	PERIOD FROM 7/ 1/2008 TO 6/30/2009	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / /	
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY				INTERMEDIARY NO:	

ELECTRONICALLY FILED COST REPORT DATE: 12/ 8/2009 TIME 11:00

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISIONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
FAIRFIELD MEMORIAL HOSPITAL 14-1311
FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2008 AND ENDING 6/30/2009 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			A	B		
		1	2	3	4	
1	HOSPITAL	0	-69,085	-453,966	0	
5	HOSPITAL-BASED SNF	0	0	0	0	
6	HOSPITAL-BASED NF	0	0	0	0	
7	HOSPITAL-BASED HHA	0	0	0	0	
9	RHC	0	0	69,946	0	
100	TOTAL	0	-69,085	-384,020	0	

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96 (12/2008)

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | PREPARED 12/ 8/2009 | WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 303 NW 11TH ST P.O. BOX:
1.01 CITY: FAIRFIELD STATE: IL ZIP CODE: 62837- COUNTY: WAYNE

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

	COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX
	0	1	2	2.01	3	4	5	6
02.00	HOSPITAL	FAIRFIELD MEMORIAL HOSPITAL	14-1311		4/ 1/2001	N	O	O
06.00	HOSPITAL-BASED SNF	FAIRFIELD MEMORIAL HOSPITAL	14-5552		3/26/1985	N	P	N
07.00	HOSPITAL-BASED NF	FAIRFIELD MEMORIAL HOSPITAL WAYFAIR	14-0000		7/ 1/1966	N		O
09.00	HOSPITAL-BASED HHA	FAIRFIELD MEMORIAL HOSPITAL	14-7612		5/ 1/1995	N	P	N
14.00	HOSPITAL-BASED RHC	FAIRFIELD RHC	14-8500		3/13/2009	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 7/ 1/2008 TO: 6/30/2009

		1	2			
18	TYPE OF CONTROL	2				

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL	1				
20	SUBPROVIDER					

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YDUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YDUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.					
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106?	N				
21.02	HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).					
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIDNS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	2	N		Y	9914
21.04	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	2				
21.05	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	2				
21.06	DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL; UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL DUTPATIENT SERVICES UNDER DRA §5105 OR MIPPA §147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO.	N				
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	N				
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW.	N				
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATIDN IN COL. 3.			/ /	/ /	
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATIDN IN COL. 3.			/ /	/ /	
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.			/ /	/ /	
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.			/ /	/ /	
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.			/ /	/ /	
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATIDN IN COL. 3.			/ /	/ /	
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.			/ /	/ /	
24	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (DPO), ENTER THE OPO NUMBER IN COLUMN 2 AND CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) in column 3 (mm/dd/yyyy)				/ /	
24.01	IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy).				/ /	
25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R?	N				
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?					
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.					
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.					
25.04	ARE YOU CLAIMING COSTS DN LINE 70 OF WORKSHEET A? IF YES, COMPLETE WDRKSHEET D-2, PART I.	N				
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FDR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)					

25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)					
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH),ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0				
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /					
26.02	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /					
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	N	/ /			
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02	N				
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)	1 100	2 0.8335	3 0.8386	4	
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY	256.96	2	14	99914	

A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)

		%	Y/N
28.03	STAFFING	1.00%	Y
28.04	RECRUITMENT	0.00%	
28.05	RETENTION	0.00%	
28.06	TRAINING	0.00%	
28.07		0.00%	
28.08		0.00%	
28.09		0.00%	
28.10		0.00%	
28.11		0.00%	
28.12		0.00%	
28.13		0.00%	
28.14		0.00%	
28.15		0.00%	
28.16		0.00%	
28.17		0.00%	
28.18		0.00%	
28.19		0.00%	
28.20		0.00%	

29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	N		
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)	Y		
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70	N		
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)	N		
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).	N		
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II	N		
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N		
31.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N		
31.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N		
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N		
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N		
31.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N		

MISCELLANEOUS COST REPORT INFORMATION

32	IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2.	N	
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2	N	N
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA?	N	
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	
35.01	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	
35.02	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	
35.03	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	
35.04	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	

		V	XVIII	XIX
	PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL	1	2	3

36	OO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS)	N	N	N
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?	N	N	N

TITLE XIX INPATIENT SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	Y
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	N
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	N
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	N
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	N

40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COL 2 THE HOME OFFICE PROVIDER NUMBER. IF THIS FACILITY IS PART DF A CHAIN ORGANIZATION ENTER THE NAME AND ADDRESS OF THE HOME OFFICE	Y	
40.01	NAME: FI/CONTRACTOR NAME		FI/CONTRACTOR #
40.02	STREET: P.O. BOX:		
40.03	CITY: STATE: ZIP CODE: -		
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
42.02	ARE SPEECH PATHDLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY?	N	
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.	N	00/00/0000
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?		
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?		
45.03	WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?		
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).		

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES, ENTER "Y" FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION. ENTER "N" IF NOT EXEMPT. (SEE 42 CFR 413.13.)

		PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
		1	2	3	4	5
47.00	HOSPITAL	N	N	N	N	N
49.00	SNF	N	N			
50.00	HHA	N	N			

52	DOES THIS HDSPITAL CLAIM EXPENDITURES FOR EXTRADRDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIDNS)	N	
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV	N	
53	IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER DF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0	
53.01	MDH PERIOD: BEGINNING: / / ENDING: / /		
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 0 PAID LDSSES: 0 AND/OR SELF INSURANCE: 0		
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMDUNTS CONTAINED THEREIN.	N	
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO.	N	

		DATE 0	Y OR N 1	LIMIT 2	Y OR N 3	FEES 4
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.		N	0.00		0
56.01	ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMDUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.			0.00		0
56.02	THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03	FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0

57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?	N	
58	ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.	N	
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y"FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).		0
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2		

"Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORT FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES DR "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN CDL. 3. (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS) 0

MULTICAMPUS

61.00 IS THIS FACILITY PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSA? ENTER "Y" FOR YES AND "N" FOR NO.

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL.2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00						0.00
62.01						0.00
62.02						0.00
62.03						0.00
62.04						0.00
62.05						0.00
62.06						0.00
62.07						0.00
62.08						0.00
62.09						0.00

SETTLEMENT DATA

63.00 WAS THE COST REPDRT FILED USING THE PS&R (EITHER IN ITS ENTIRETY DR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). / /

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96 (04/2005)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | PREPARED 12/ 8/2009 | WORKSHEET S-3 PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	I/P DAYS / TITLE V 3	I/P DAYS / TITLE XVIII 4	O/P VISITS / NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	21	7,665	85,800.00		2,282		486
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	21	7,665	85,800.00		2,282		486
6	INTENSIVE CARE UNIT	4	1,460	9,792.00		286		
11	NURSERY							
12	TOTAL	25	9,125	95,592.00		2,568		486
13	RPCH VISITS							
15	SKILLED NURSING FACILITY	30	10,950			2,489		
16	NURSING FACILITY	104	37,960					23,766
18	HOME HEALTH AGENCY					3,913		
24	RURAL HEALTH CLINIC					1,443		
25	TOTAL	159						
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							

	COMPONENT	I/P DAYS / TITLE XIX ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	TRIPS TOTAL OBSERVATION BEDS ADMITTED 6.01	TRIPS TOTAL OBSERVATION BEDS NOT ADMITTED 6.02	INTERNS & RES. FTES TOTAL 7	INTERNS & RES. FTES LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			3,270				
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS			3,270				
6	INTENSIVE CARE UNIT			429				
11	NURSERY			42				
12	TOTAL			3,741				
13	RPCH VISITS							
15	SKILLED NURSING FACILITY			6,158				
16	NURSING FACILITY			29,456				
18	HOME HEALTH AGENCY			5,039				
24	RURAL HEALTH CLINIC			4,734				
25	TOTAL							
26	OBSERVATION BED DAYS			740		740		
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							

	COMPONENT	I & R FTES NET 9	FULL TIME EQUIV EMPLOYEES ON PAYROLL 10	FULL TIME EQUIV NONPAID WORKERS 11	DISCHARGES TITLE V 12	DISCHARGES TITLE XVIII 13	DISCHARGES TITLE XIX 14	DISCHARGES TOTAL ALL PATIENTS 15
1	ADULTS & PEDIATRICS					716	174	1,188
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
6	INTENSIVE CARE UNIT							
11	NURSERY							
12	TOTAL		161.87			716	174	1,188
13	RPCH VISITS							
15	SKILLED NURSING FACILITY		17.16					
16	NURSING FACILITY		78.83					
18	HOME HEALTH AGENCY		6.20					
24	RURAL HEALTH CLINIC		4.60					
25	TOTAL		268.66					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

PROVIDER NO:	PERIOD:		PREPARED 12/ 8/2009
14-1311	FROM 7/ 1/2008		WORKSHEET S-4
HHA NO:	TO 6/30/2009		
14-7612			
	COUNTY:	WAYNE	

HOME HEALTH AGENCY STATISTICAL DATA

HHA 1

		TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4
1	HOME HEALTH AIDE HOURS	0	0	0	0
2	UNDUPLICATED CENSUS COUNT		160.00		52.00

		TOTAL 5
1	HOME HEALTH AIDE HOURS	0
2	UNDUPLICATED CENSUS COUNT	212.00

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES
(FULL TIME EQUIVALENT)

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK 40.00

HHA NO. OF FTE EMPLOYEES (2080 HRS)

		STAFF 1	CONTRACT 2	TOTAL 3
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)			
4	DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			
5	OTHER ADMINISTRATIVE PERSONEL			
6	DIRECTING NURSING SERVICE			
7	NURSING SUPERVISOR			
8	PHYSICAL THERAPY SERVICE			
9	PHYSICAL THERAPY SUPERVISOR			
10	OCCUPATIONAL THERAPY SERVICE			
11	OCCUPATIONAL THERAPY SUPERVISOR			
12	SPEECH PATHOLOGY SERVICE			
13	SPEECH PATHOLOGY SUPERVISOR			
14	MEDICAL SOCIAL SERVICE			
15	MEDICAL SOCIAL SERVICE SUPERVISOR			
16	HOME HEALTH AIDE			
17	HOME HEALTH AIDE SUPERVISOR			
18				

	HOME HEALTH AGENCY MSA CODES	1	1.01
19	HOW MANY MSAs IN COL. 1 OR CBSAs IN COL. 1.01 DID YOU PROVIDER SERVICES TO DURING THE C/R PERIOD?	1	0
20	LIST THOSE MSA CODE(S) IN COL. 1 & CBSA CODE(S) IN COL. 1.01 SERVICED DURING THIS C/R PERIOD (LINE 20 CONTAINS THE FIRST CODE).	9914	

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES ON
OR AFTER OCTOBER 1, 2000

		FULL EPISODES WITHOUT OUTLIERS 1	FULL EPISODES WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4
21	SKILLED NURSING VISITS	2,270	683	14	18
22	SKILLED NURSING VISIT CHARGES	249,700	75,130	1,540	1,980
23	PHYSICAL THERAPY VISITS	777	0	1	14
24	PHYSICAL THERAPY VISIT CHARGES	85,470	0	110	1,540
25	OCCUPATIONAL THERAPY VISITS	100	0	0	0
26	OCCUPATIONAL THERAPY VISIT CHARGES	11,000	0	0	0
27	SPEECH PATHOLOGY VISITS	20	0	0	0
28	SPEECH PATHOLOGY VISIT CHARGES	2,300	0	0	0
29	MEDICAL SOCIAL SERVICE VISITS	0	0	0	0
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	0	0
31	HOME HEALTH AIDE VISITS	16	0	0	0
32	HOME HEALTH AIDE VISIT CHARGES	992	0	0	0
33	TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	3,183	683	15	32
34	OTHER CHARGES	32,408	14,047	195	245
35	TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	381,870	89,177	1,845	3,765
36	TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	217	0	5	3
37	TOTAL NUMBER OF OUTLIER EPISODES	0	13	0	0
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	11,128	7,370	81	192

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HOME HEALTH AGENCY STATISTICAL DATA

PROVIDER NO: 14-1311
HHA NO: 14-7612
PERIOD: FROM 7/ 1/2008 TO 6/30/2009
COUNTY: WAYNE

PREPARED 12/ 8/2009
WORKSHEET S-4

HHA 1

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES ON OR AFTER OCTOBER 1, 2000

		SCIC WITHIN A PEP 5	SCIC ONLY EPISODES 6	TOTAL (COLS. 1-6) 7
21	SKILLED NURSING VISITS	0	0	2,985
22	SKILLED NURSING VISIT CHARGES	0	0	328,350
23	PHYSICAL THERAPY VISITS	0	0	792
24	PHYSICAL THERAPY VISIT CHARGES	0	0	87,120
25	OCCUPATIONAL THERAPY VISITS	0	0	100
26	OCCUPATIONAL THERAPY VISIT CHARGES	0	0	11,000
27	SPEECH PATHOLOGY VISITS	0	0	20
28	SPEECH PATHOLOGY VISIT CHARGES	0	0	2,300
29	MEDICAL SOCIAL SERVICE VISITS	0	0	0
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	0
31	HOME HEALTH AIDE VISITS	0	0	16
32	HOME HEALTH AIDE VISIT CHARGES	0	0	992
33	TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	0	0	3,913
34	OTHER CHARGES	0	0	46,895
35	TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	0	0	476,657
36	TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	0	0	225
37	TOTAL NUMBER OF OUTLIER EPISODES	0	0	13
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	0	0	18,771

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET S-7

	GROUP(1)	M3PI REVENUE CODE	SERVICES PRIOR TO 10/1 RATE	SERVICES PRIOR TO 10/1 DAYS	SERVICES ON/AFTER 10/1 RATE	SERVICES ON/AFTER 10/1 DAYS	SRVCS 4/1/01 TO 9/30/01 RATE	SRVCS 4/1/01 TO 9/30/01 DAYS
	1	2	3	3.01	4	4.01	4.02	4.03
1		RUC		28				
2		RUB		191				
3		RUA		65				
3	.01	RUX		67				
3	.02	RUL		233				
4		RVC		79				
5		RVB		166				
6		RVA		68				
6	.01	RVX		53				
6	.02	RVL		164				
7		RHC		117				
8		RHB		263				
9		RHA		111				
9	.01	RHX						
9	.02	RHL						
10		RMC						
11		RMB		46				
12		RMA		102				
12	.01	RMX		114				
12	.02	RML		397				
13		RLB						
14		RLA						
14	.01	RLX						
15		SE3		18				
16		SE2		89				
17		SE1		3				
18		SSC						
19		SSB						
20		SSA		85				
21		CC2						
22		CC1		16				
23		CB2						
24		CB1						
25		CA2						
26		CA1		14				
27		IB2						
28		IB1						
29		IA2						
30		IA1						
31		BB2						
32		BB1						
33		BA2						
34		BA1						
35		PE2						
36		PE1						
37		PD2						
38		PD1						
39		PC2						
40		PC1						
41		PB2						
42		PB1						
43		PA2						
44		PA1						
45		AAA						
46		TOTAL		2,489				

(1) Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on after October 1st. Enter in column 4.03 the days on 4/1/2001 through 9/30/2001. The sum of the days in column 3.01, 4.01, and 4.03 must agree with the days reported on Wkst. S-3, Part I, column 4, line 15. The sum of the days in column 4.06 must agree with the days reported on Wkst S-3, Part I column 4, line 3.

Worksheet S-2 reference data:

Transition Period	100% Federal
Wage Index Factor (before 10/01)	0.8335
Wage Index Factor (after 10/01)	0.8386
SNF Facility Specific Rate	256.96
Urban/Rural Designation	RURAL
SNF MSA Code	14
SNF CBSA Code	99914

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET S-7

	GROUP(1)	M3PI REVENUE CODE	HIGH COST(2) RUGs DAYS	SWING BED SNF DAYS	TOTAL
	1	2	4.05	4.06	5
1		RUC			
2		RUB			
3		RUA			
3	.01	RUX			
3	.02	RUL			
4		RVC			
5		RVB			
6		RVA			
6	.01	RVX			
6	.02	RVL			
7		RHC			
8		RHB			
9		RHA			
9	.01	RHX			
9	.02	RHL			
10		RMC			
11		RMB			
12		RMA			
12	.01	RMX			
12	.02	RML			
13		RLB			
14		RLA			
14	.01	RLX			
15		SE3			
16		SE2			
17		SE1			
18		SSC			
19		SSB			
20		SSA			
21		CC2			
22		CC1			
23		CB2			
24		CB1			
25		CA2			
26		CA1			
27		IB2			
28		IB1			
29		IA2			
30		IA1			
31		BB2			
32		BB1			
33		BA2			
34		BA1			
35		PE2			
36		PE1			
37		PD2			
38		PD1			
39		PC2			
40		PC1			
41		PB2			
42		PB1			
43		PA2			
44		PA1			
45		AAA			
46		TOTAL			

(2) Enter in column 4.05 those days in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000. These RUGs will be incremented by an additional 20% payment.

(3) Enter in column 4.06 the swing bed days for cost reporting periods beginning on or after 7/1/2002.

Worksheet S-2 reference data:

Transition Period	100% Federal
Wage Index Factor (before 10/01)	0.8335
Wage Index Factor (after 10/01)	0.8386
SNF Facility Specific Rate	256.96
Urban/Rural Designation	RURAL
SNF MSA Code	14
SNF CBSA Code	99914

	GROUP(1) 1	M3PI REVENUE CODE	SERVICES BASE RATE 3a	PRIOR TO OCTOBER 1ST RATE 3	OCTOBER 1ST DAYS 3.01	SERVICES BASE RATE 4a	ON OR AFTER OCTOBER 1ST RATE 4	OCTOBER 1ST DAYS 4.01
1	RUC		478.65			497.80	497.80	28
2	RUB		442.78			460.49	460.49	191
3	RUA		424.23			441.19	441.19	65
3 .01	RUX		555.34			577.55	577.55	67
3 .02	RUL		493.49			513.24	513.24	233
4	RVC		378.00			393.12	393.12	79
5	RVB		360.68			375.12	375.12	166
6	RVA		327.29			340.39	340.39	68
6 .01	RVX		416.34			433.00	433.00	53
6 .02	RVL		390.37			405.99	405.99	164
7	RHC		323.91			336.86	336.86	117
8	RHB		310.31			322.72	322.72	263
9	RHA		289.28			300.84	300.84	111
9 .01	RHX		348.65			362.60		
9 .02	RHL		342.47			356.16		
10	RMC		296.13			307.99		
11	RMB		288.72			300.27	300.27	46
12	RMA		282.53			293.84	293.84	102
12 .01	RMX		392.62			408.32	408.32	114
12 .02	RML		361.69			376.16	376.16	397
13	RLB		256.66			266.93		
14	RLA		220.79			229.62		
14 .01	RLX		277.69			288.79		
15	SE3		311.09			323.53	323.53	18
16	SE2		265.33			275.94	275.94	89
17	SE1		236.87			246.34	246.34	3
18	SSC		233.17			242.48		
19	SSB		220.79			229.62		
20	SSA		217.09			225.77	225.77	85
21	CC2		231.93			241.20		
22	CC1		212.13			220.62	220.62	16
23	CB2		202.24			210.32		
24	CB1		193.58			201.32		
25	CA2		192.34			200.03		
26	CA1		179.97			187.17	187.17	14
27	IB2		172.55			179.45		
28	IB1		170.08			176.88		
29	IA2		156.47			162.73		
30	IA1		150.28			156.29		
31	BB2		171.32			178.17		
32	BB1		166.37			173.02		
33	BA2		155.24			161.44		
34	BA1		145.34			151.15		
35	PE2		186.16			193.60		
36	PE1		182.45			189.75		
37	PD2		177.50			184.60		
38	PD1		175.03			182.03		
39	PC2		168.85			175.59		
40	PC1		166.37			173.02		
41	PB2		149.05			155.01		
42	PB1		147.81			153.72		
43	PA2		146.57			152.43		
44	PA1		142.87			148.58		
45	AAA		142.87			148.58		
46	TOTAL							2,489

(1) Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on after October 1st. Enter in column 4.03 the days on 4/1/2001 through 9/30/2001. The sum of the days in column 3.01, 4.01, and 4.03 must agree with the days reported on Wkst. S-3, Part I, column 4, line 15. The sum of the days in column 4.06 must agree with the days reported on Wkst S-3, Part I column 4, line 3.

Worksheet S-2 reference data:
Transition Period : 100% Federal
Wage Index Factor (before 10/01): 0.8335
Wage Index Factor (after 10/01) : 0.8386
SNF Facility Specific Rate : 256.96
Urban/Rural Designation : RURAL
SNF MSA Code : 14
SNF CBSA Code : 99914

Non-CMS S-7 options selected:
[x] Calculate Total Days from this worksheet.
[x] Transfer total to settlement worksheet.

	GROUP(1)	M3PI REVENUE CODE	AIDS DIAGNOSIS CODE 042 SERV PRIOR TO OCT. 1ST RATE	AIDS DIAGNOSIS CODE 042 SERV PRIOR TO OCT. 1ST DAYS	AIDS DIAGNOSIS CODE 042 SERV ON/AFTEER OCT. 1ST RATE	AIDS DIAGNOSIS CODE 042 SERV ON/AFTEER OCT. 1ST DAYS	SWING BED SNF DAYS	TOTAL
	1	2	4.02	4.03	4.04	4.05	4.06	5
1	RUC		1,091.32		1,134.98			13,938
2	RUB		1,009.54		1,049.92			87,954
3	RUA		967.24		1,005.91			28,677
3 .01	RUX		1,266.18		1,316.81			38,696
3 .02	RUL		1,125.16		1,170.19			119,585
4	RVC		861.84		896.31			31,056
5	RVB		822.35		855.27			62,270
6	RVA		746.22		776.09			23,147
6 .01	RVX		949.26		987.24			22,949
6 .02	RVL		890.04		925.66			66,582
7	RHC		738.51		768.04			39,413
8	RHB		707.51		735.80			84,875
9	RHA		659.56		685.92			33,393
9 .01	RHX		794.92		826.73			
9 .02	RHL		780.83		812.04			
10	RMC		675.18		702.22			
11	RMB		658.28		684.62			13,812
12	RMA		644.17		669.96			29,972
12 .01	RMX		895.17		930.97			46,548
12 .02	RML		824.65		857.64			149,336
13	RLB		585.18		608.60			
14	RLA		503.40		523.53			
14 .01	RLX		633.13		658.44			
15	SE3		709.29		737.65			5,824
16	SE2		604.95		629.14			24,559
17	SE1		540.06		561.66			739
18	SSC		531.63		552.85			
19	SSB		503.40		523.53			
20	SSA		494.97		514.76			19,190
21	CC2		528.80		549.94			
22	CC1		483.66		503.01			3,530
23	CB2		461.11		479.53			
24	CB1		441.36		459.01			
25	CA2		438.54		456.07			
26	CA1		410.33		426.75			2,620
27	IB2		393.41		409.15			
28	IB1		387.78		403.29			
29	IA2		356.75		371.02			
30	IA1		342.64		356.34			
31	BB2		390.61		406.23			
32	BB1		379.32		394.49			
33	BA2		353.95		368.08			
34	BA1		331.38		344.62			
35	PE2		424.44		441.41			
36	PE1		415.99		432.63			
37	PD2		404.70		420.89			
38	PD1		399.07		415.03			
39	PC2		384.98		400.35			
40	PC1		379.32		394.49			
41	PB2		339.83		353.42			
42	PB1		337.01		350.48			
43	PA2		334.18		347.54			
44	PA1		325.74		338.76			
45	AAA		325.74		338.76			
46	TOTAL							948,665

(2) Enter in column 4.05 those days in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000. These RUGs will be incremented by an additional 20% payment.

(3) Enter in column 4.06 the swing bed days for cost reporting periods beginning on or after 7/1/2002.

Worksheet S-2 reference data:
Transition Period : 100% Federal
Wage Index Factor (before 10/01): 0.8335
Wage Index Factor (after 10/01) : 0.8386
SNF Facility Specific Rate : 256.96
Urban/Rural Designation : RURAL
SNF MSA Code : 14
SNF CBSA Code : 99914

Non-CMS S-7 options selected:
[x] Calculate Total Days from this worksheet.
[x] Transfer total to settlement worksheet.

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96 S-8 (09/2000)

PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA

PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | PREPARED 12/ 8/2009

COMPONENT NO: 14-8500 | WORKSHEET S-8

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 303 NW 11TH ST

1.01 CITY: FAIRFIELD STATE: IL ZIP CODE: 62837 COUNTY: WAYNE

2 DESIGNATION (FOR FQHCS ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN: R

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD 1	DATE 2
3	COMMUNITY HEALTH CENTER (SECTION 339(d), PHS ACT)		/ /
4	MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)		/ /
5	HEALTH SERVICES FOR THE HOMELESS (SECTION 340(d), PHS ACT)		/ /
6	APPALACHIAN REGIONAL COMMISSION		/ /
7	LOOK-ALIKES		/ /
8	OTHER (SPECIFY)		/ /

PHYSICIAN INFORMATION:

		PHYSICIAN NAME	BILLING NUMBER
9	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	BALLARD	
9.01	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	THOMPSON	
9.02	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	KAKAC	

		PHYSICIAN NAME	HOURS OF SUPERVISION
11	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS.)		N

FACILITY HOURS OF OPERATIONS (1)

		SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	TYPE OPERATION	FROM 1	TO 2	FROM 3	TO 4	FROM 5	TO 6	FROM 7	TO 8	FROM 9	TO 10	FROM 11	TO 12	FROM 13	TO 14
	0														
12	CLINIC			900	500	900	500	900	500	900	500	900	500		

(1) ENTER CLINIC HOURS OF OPERATIONS ON SUBSCRIPTS OF LINE 12 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? Y

14 IS THIS A CONSOLIDATED COST REPORT DEFINED IN THE RURAL HEALTH CLINIC MANUAL? IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS INCLUDED IN THIS REPORT, COMPLETE LINE 15 AND COMPLETE ONLY ONE WORKSHEET SERIES M FOR THE CONSOLIDATED GROUP. IF NO, COMPLETE A SEPARATE WORKSHEET S-8 FOR EACH COMPONENT ACCOMPANIED BY A CORRESPONDING WORKSHEET M SERIES. N

15 PROVIDER NAME: FAIRFIELD RHC I PROVIDER NUMBER:

		TITLE V	TITLE XVIII	TITLE XIX
16	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS & RESIDENTS.	N		
17	HAS THE HOSPITALS' BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? IF YES, SEE INSTRUCTIONS.		N	

HOSPITAL UNCOMPENSATED CARE DATA

PROVIDER NO:	PERIOD:	PREPARED 12/ 8/2009
14-1311	FROM 7/ 1/2008	WORKSHEET S-10
	TO 6/30/2009	

	DESCRIPTION	
	UNCOMPENSATED CARE INFORMATION	
1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04	
2.01	IS IT AT THE TIME OF ADMISSION?	
2.02	IS IT AT THE TIME OF FIRST BILLING?	
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?,	
2.04	Other methods of write-offs (speci	
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?	
4	ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?	
5	ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?	
6	ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA?	
7	ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA?	
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01	
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?	
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?	
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF?	
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04	
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?	
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?	
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?	
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?	
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?	
14	IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02	
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE?	
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?	
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?	
	UNCOMPENSATED CARE REVENUES	
17	REVENUE FROM UNCOMPENSATED CARE	28,761
17.01	GROSS MEDICAID REVENUES	1,996,785
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)	
20	RESTRICTED GRANTS	
21	NON-RESTRICTED GRANTS	
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	2,025,546
	UNCOMPENSATED CARE COST	
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	
24	COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103)	.429574
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)	
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	

HOSPITAL UNCOMPENSATED CARE DATA

PROVIDER NO: 14-1311 PERIOD: FROM 7/ 1/2008 TO 6/30/2009 PREPARED 12/ 8/2009

WORKSHEET S-10

	DESCRIPTION	
27	TOTAL SCHIP COST, (LINE 24 * LINE 26)	
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	7,765,320
29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	3,335,780
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL (SUM OF LINES 25, 27, AND 29)	3,335,780

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		679,348	679,348		679,348
4	0400	NEW CAP REL COSTS-MVBLE EQUIP				406,984	406,984
5	0500	EMPLOYEE BENEFITS	49,408	2,254,823	2,304,231		2,304,231
6	0600	ADMINISTRATIVE & GENERAL	851,179	2,484,351	3,335,530	74,365	3,409,895
7	0700	MAINTENANCE & REPAIRS	207,475	251,187	458,662	-539	458,123
8	0800	OPERATION OF PLANT		389,629	389,629		389,629
9	0900	LAUNDRY & LINEN SERVICE		212,205	212,205		212,205
10	1000	HOUSEKEEPING	203,764	96,821	300,585		300,585
11	1100	DIETARY	208,008	297,391	505,399	-214,263	291,136
12	1200	CAFETERIA				212,607	212,607
14	1400	NURSING ADMINISTRATION	207,750	13,199	220,949		220,949
17	1700	MEDICAL RECORDS & LIBRARY	214,545	47,915	262,460	-1,274	261,186
18	1800	SOCIAL SERVICE	64,741	4,119	68,860		68,860
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	1,114,106	39,423	1,153,529	-14,333	1,139,196
26	2600	INTENSIVE CARE UNIT	225,674	5,883	231,557		231,557
33	3300	NURSERY				10,282	10,282
34	3400	SKILLED NURSING FACILITY	537,205	66,408	603,613	-5,600	598,013
35	3500	NURSING FACILITY	2,146,656	1,441,806	3,588,462		3,588,462
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	941,524	227,352	1,168,876		1,168,876
39	3900	DELIVERY ROOM & LABOR ROOM				3,183	3,183
41	4100	RADIOLOGY-DIAGNOSTIC	412,430	1,161,414	1,573,844	-232,851	1,340,993
44	4400	LABORATORY	730,358	1,050,102	1,780,460	-88,618	1,691,842
49	4900	RESPIRATORY THERAPY	132,600	102,531	235,131	-79,672	155,459
50	5000	PHYSICAL THERAPY	597,332	55,942	653,274	-2,731	650,543
53	5300	ELECTROCARDIOLOGY				67,875	67,875
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,130	710,596	753,726	-1,874	751,852
56	5600	DRUGS CHARGED TO PATIENTS	214,092	1,105,742	1,319,834		1,319,834
59	3550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	181,881	126,603	308,484		308,484
		OUTPAT SERVICE COST CNTRS					
61	6100	EMERGENCY	550,221	1,251,310	1,801,531	-3,876	1,797,655
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950	OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310	RURAL HEALTH CLINIC				575,387	575,387
		OTHER REIMBURS COST CNTRS					
71	7100	HOME HEALTH AGENCY	279,185	71,054	350,239	-1,874	348,365
		SPEC PURPOSE COST CENTERS					
88	8800	INTEREST EXPENSE		155,492	155,492	-122,914	32,578
95		SUBTOTALS	10,113,264	14,302,646	24,415,910	580,264	24,996,174
		NONREIMBURS COST CENTERS					
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
100	7950	DR. OFFICE	1,205,120	357,337	1,562,457	-580,264	982,193
101		TOTAL	11,318,384	14,659,983	25,978,367	-0-	25,978,367

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
			6	7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT	-99,205	580,143
4	0400	NEW CAP REL COSTS-MVBLE EQUIP	-546	406,438
5	0500	EMPLOYEE BENEFITS		2,304,231
6	0600	ADMINISTRATIVE & GENERAL	-213,321	3,196,574
7	0700	MAINTENANCE & REPAIRS		458,123
8	0800	OPERATION OF PLANT		389,629
9	0900	LAUNDRY & LINEN SERVICE		212,205
10	1000	HOUSEKEEPING		300,585
11	1100	DIETARY		291,136
12	1200	CAFETERIA	-124,023	88,584
14	1400	NURSING ADMINISTRATION		220,949
17	1700	MEDICAL RECORDS & LIBRARY	-6,602	254,584
18	1800	SOCIAL SERVICE		68,860
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS	-100	1,139,096
26	2600	INTENSIVE CARE UNIT		231,557
33	3300	NURSERY		10,282
34	3400	SKILLED NURSING FACILITY		598,013
35	3500	NURSING FACILITY		3,588,462
		ANCILLARY SRVC COST CNTRS		
37	3700	OPERATING ROOM	-406,205	762,671
39	3900	DELIVERY ROOM & LABOR ROOM		3,183
41	4100	RADIOLOGY-DIAGNOSTIC	-4,832	1,336,161
44	4400	LABORATORY		1,691,842
49	4900	RESPIRATORY THERAPY		155,459
50	5000	PHYSICAL THERAPY		650,543
53	5300	ELECTROCARDIOLOGY	-33,236	34,639
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		751,852
56	5600	DRUGS CHARGED TO PATIENTS		1,319,834
59	3550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		308,484
		OUTPAT SERVICE COST CNTRS		
61	6100	EMERGENCY	-789,617	1,008,038
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950	OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310	RURAL HEALTH CLINIC		575,387
		OTHER REIMBURS COST CNTRS		
71	7100	HOME HEALTH AGENCY		348,365
		SPEC PURPOSE COST CENTERS		
88	8800	INTEREST EXPENSE	-32,578	-0-
95		SUBTOTALS	-1,710,265	23,285,909
		NONREIMBURS COST CENTERS		
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		
100	7950	DR. OFFICE		982,193
101		TOTAL	-1,710,265	24,268,102

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
I 14-1311 I FROM 7/ 1/2008 I NOT A CMS WORKSHEET
I I TO 6/30/2009 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
33	NURSERY	3300	
34	SKILLED NURSING FACILITY	3400	
35	NURSING FACILITY	3500	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
39	DELIVERY ROOM & LABOR ROOM	3900	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES
	OUTPAT SERVICE COST		
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
100	DR. OFFICE	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	LINE NO	INCREASE SALARY	INCREASE OTHER
		1	2	3	4	5
1	CAFETERIA	A	CAFETERIA	12	87,503	125,104
2	L&D/NURSERY	B	NURSERY	33	10,282	
3			DELIVERY ROOM & LABOR ROOM	39	3,183	
4	EKG	C	ELECTROCARDIOLOGY	53	34,639	33,236
5	RENTAL	D	NEW CAP REL COSTS-MVBLE EQUIP	4		406,984
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19	INTEREST	E	ADMINISTRATIVE & GENERAL	6		122,914
20	RHC EXPENSE	F	RURAL HEALTH CLINIC	63.50	482,993	97,271
36	TOTAL RECLASSIFICATIONS				618,600	785,509

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.
See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	LINE NO	DECREASE SALARY	DECREASE OTHER	A-7 REF
		1	6	7	8	9	10
1	CAFETERIA	A	DIETARY	11	87,503	125,104	
2	L&D/NURSERY	B	ADULTS & PEDIATRICS	25	13,465		
3							
4	EKG	C	RESPIRATORY THERAPY	49	34,639	33,236	
5	RENTAL	D	ADMINISTRATIVE & GENERAL	6		48,549	10
6			MAINTENANCE & REPAIRS	7		539	
7			DIETARY	11		1,656	
8			MEDICAL RECORDS & LIBRARY	17		1,274	
9			ADULTS & PEDIATRICS	25		868	
10			SKILLED NURSING FACILITY	34		5,600	
11			RADIOLOGY-DIAGNOSTIC	41		232,851	
12			LABORATORY	44		88,618	
13			RESPIRATORY THERAPY	49		11,797	
14			PHYSICAL THERAPY	50		2,731	
15			MEDICAL SUPPLIES CHARGED TO PATIENTS	55		1,874	
16			EMERGENCY	61		3,876	
17			RURAL HEALTH CLINIC	63.50		4,877	
18			HOME HEALTH AGENCY	71		1,874	
19	INTEREST	E	INTEREST EXPENSE	88		122,914	
20	RHC EXPENSE	F	DR. OFFICE	100	482,993	97,271	
36	TOTAL RECLASSIFICATIONS				618,600	785,509	

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.
See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

RECLASS CODE: A
EXPLANATION : CAFETERIA

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	212,607	DIETARY	11	212,607
TOTAL RECLASSIFICATIONS FOR CODE A			212,607			212,607

RECLASS CODE: B
EXPLANATION : L&D/NURSERY

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NURSERY	33	10,282	ADULTS & PEDIATRICS	25	13,465
2.00	DELIVERY ROOM & LABOR ROOM	39	3,183			0
TOTAL RECLASSIFICATIONS FOR CODE B			13,465			13,465

RECLASS CODE: C
EXPLANATION : EKG

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ELECTROCARDIOLOGY	53	67,875	RESPIRATORY THERAPY	49	67,875
TOTAL RECLASSIFICATIONS FOR CODE C			67,875			67,875

RECLASS CODE: D
EXPLANATION : RENTAL

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	406,984	ADMINISTRATIVE & GENERAL	6	48,549
2.00			0	MAINTENANCE & REPAIRS	7	539
3.00			0	DIETARY	11	1,656
4.00			0	MEDICAL RECORDS & LIBRARY	17	1,274
5.00			0	ADULTS & PEDIATRICS	25	868
6.00			0	SKILLED NURSING FACILITY	34	5,600
7.00			0	RADIOLOGY-DIAGNOSTIC	41	232,851
8.00			0	LABORATORY	44	88,618
9.00			0	RESPIRATORY THERAPY	49	11,797
10.00			0	PHYSICAL THERAPY	50	2,731
11.00			0	MEDICAL SUPPLIES CHARGED TO PA	55	1,874
12.00			0	EMERGENCY	61	3,876
13.00			0	RURAL HEALTH CLINIC	63.50	4,877
14.00			0	HOME HEALTH AGENCY	71	1,874
TOTAL RECLASSIFICATIONS FOR CODE D			406,984			406,984

RECLASS CODE: E
EXPLANATION : INTEREST

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	122,914	INTEREST EXPENSE	88	122,914
TOTAL RECLASSIFICATIONS FOR CODE E			122,914			122,914

RECLASS CODE: F
EXPLANATION : RHC EXPENSE

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	RURAL HEALTH CLINIC	63.50	580,264	DR. OFFICE	100	580,264
TOTAL RECLASSIFICATIONS FOR CODE F			580,264			580,264

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1996)

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS

PROVIDER NO: 14-1311 PERIOD: FROM 7/ 1/2008 TO 6/30/2009 PREPARED 12/ 8/2009

WORKSHEET A-7 PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS PURCHASES	ACQUISITIONS DONATION	ACQUISITIONS TOTAL	DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		1	2	3	4	5	6	7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT							
7	SUBTOTAL							
8	RECONCILING ITEMS							
9	TOTAL							

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS PURCHASES	ACQUISITIONS DONATION	ACQUISITIONS TOTAL	DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		1	2	3	4	5	6	7
1	LAND	200,922	47,726		47,726		248,648	
2	LAND IMPROVEMENTS	322,532	8,350		8,350		330,882	
3	BUILDINGS & FIXTURE	11,643,155	1,822,117		1,822,117		13,465,272	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT	696,495					696,495	
6	MOVABLE EQUIPMENT	6,843,053	608,325		608,325		7,451,378	
7	SUBTOTAL	19,706,157	2,486,518		2,486,518		22,192,675	
8	RECONCILING ITEMS							
9	TOTAL	19,706,157	2,486,518		2,486,518		22,192,675	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS	CAPITLIZED GROSS ASSETS LEASES	FOR RATIO	RATIO	ALLOCATION OF OTHER CAPITAL INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	TOTAL
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	12,256,249		12,256,249	.653740				
4	NEW CAP REL COSTS-MV	6,491,648		6,491,648	.346260				
5	TOTAL	18,747,897		18,747,897	1.000000				

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED CDST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	643,167	-63,024					580,143
4	NEW CAP REL COSTS-MV	-546	406,984					406,438
5	TOTAL	642,621	343,960					986,581

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, CDLUMN 2, LINES 1 THRU 4

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	679,348						679,348
4	NEW CAP REL COSTS-MV							
5	TOTAL	679,348						679,348

* All lines numbers except line 5 are to be consistent with Workhseet A line numbers for capital cost centers.
(1) The amounts on lines 1 thru 4 must equal the corresponding amounts on Worksheet A, column 7, lines 1 thru 4.
Columns 9 through 14 should include related Worksheet A-6 reclassifications and Worksheet A-8 adjustments. (See instructions).

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4	WKST. A-7 REF. 5
1	INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5	INVESTMENT INCOME-OTHER	B	-32,578	INTEREST EXPENSE	88	
6	TRADE, QUANTITY AND TIME DISCOUNTS					
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES	A	-4,555	ADMINISTRATIVE & GENERAL	6	
10	TELEVISION AND RADIO SERVICE					
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-1,229,058			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1	-4,832			
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS	B	-124,023	CAFETERIA	12	
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS					
20	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-6,602	MEDICAL RECORDS & LIBRARY	17	
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES					
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32	DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33	NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37	OFFICE SPACE	B	-63,024	NEW CAP REL COSTS-BLDG &	3	10
38	BABY PICS	B	-21	ADMINISTRATIVE & GENERAL	6	
39						
40	PRENATAL CLASS	B	-100	ADULTS & PEDIATRICS	25	
41	RINARD & WEBER	A	-36,181	NEW CAP REL COSTS-BLDG &	3	9
42						
43	ADVERTISING	A	-135,160	ADMINISTRATIVE & GENERAL	6	
44	MISC REV	B	-73,585	ADMINISTRATIVE & GENERAL	6	
45	LIFELINE	B	-546	NEW CAP REL COSTS-MVBLE E	4	9
46	OTHER ADJUSTMENTS (SPECIFY)					
47	OTHER ADJUSTMENTS (SPECIFY)					
48	OTHER ADJUSTMENTS (SPECIFY)					
49	OTHER ADJUSTMENTS (SPECIFY)					
50	TOTAL (SUM OF LINES 1 THRU 49)		-1,710,265			

(1) Description - all chapter references in this columnpertain to CMS Pub. 15-I.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUST-MENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1 41	RADIOLOGY-DIAGNOSTIC	MRI	218,782	223,614	-4,832	
2						
3						
4						
5	TOTALS		218,782	223,614	-4,832	

* THE AMOUNTS ON LINES 1-4 AND SUBSCRIPTS AS APPROPRIATE ARE TRANSFERRED IN DETAIL TO WORKSHEET A, COLUMN 6, LINES AS APPROPRIATE. POSITIVE AMOUNTS INCREASE COST AND NEGATIVE AMOUNTS DECREASE COST. FOR RELATED ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:
THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(B)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THIS INFORMATION IS USED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
	1	2	3	4	5	6
1	G	DIAGNOSTIC SHARED SERVICE	15.00		0.00	
2			0.00		0.00	
3			0.00		0.00	
4			0.00		0.00	
5			0.00		0.00	

(1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
- B. CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
- C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION.
- D. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS A FINANCIAL INTEREST IN RELATED ORGANIZATION.
- E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
- F. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
- G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY.
  OTHER

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUN-ERATION 3	PROFES-SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
1	37	ANESTHESIA	406,205	406,205					
2	44	LAB	26,250		26,250				
3	53	EKG	33,236	33,236					
4	61	ER	1,179,766	789,617	390,149				
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL	1,645,457	1,229,058	416,399				

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 10		COST CENTER/ PHYSICIAN IDENTIFIER 11	COST OF MEMBERSHIPS & CONTINUING EDUCATION 12	PROVIDER COMPONENT SHARE OF COL 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COL 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUSTMENT 18
1	37	ANESTHESIA								406,205
2	44	LAB								
3	53	EKG								33,236
4	61	ER								789,617
5										
6										
7										
8										
9										
10										
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22										
23										
24										
25										
26										
27										
28										
29										
30										
101		TOTAL								1,229,058

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1997)

COST ALLOCATION STATISTICS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I NOT A CMS WORKSHEET I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
3	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM. COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	1	SQUARE FEET	ENTERED
8	OPERATION OF PLANT	1	SQUARE FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	ENTERED
10	HOUSEKEEPING	1	SQUARE FEET	ENTERED
11	DIETARY	10	MEALS SERVED	ENTERED
12	CAFETERIA	11	PAID HOURS	ENTERED
14	NURSING ADMINISTRATION	13	DIRECT NRSING HRS	ENTERED
17	MEDICAL RECORDS & LIBRARY	14	GROSS REV	ENTERED
18	SOCIAL SERVICE	17	TIME SPENT	ENTERED

		COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	EMPLOYEE BENEFITS	SUBTOTAL	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
			0	3	4	5	5a.00	6	7
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &	580,143	580,143					
004		NEW CAP REL COSTS-MVBLE E	406,438		406,438				
005		EMPLOYEE BENEFITS	2,304,231			2,304,231			
006		ADMINISTRATIVE & GENERAL	3,196,574	50,191	35,163	215,002	3,496,930	3,496,930	
007		MAINTENANCE & REPAIRS	458,123	22,735	15,928	52,407	549,193	111,768	660,961
008		OPERATION OF PLANT	389,629	14,860	10,411		414,900	84,438	19,364
009		LAUNDRY & LINEN SERVICE	212,205	10,268	7,193		229,666	46,740	13,380
010		HOUSEKEEPING	300,585	1,421	995	51,469	354,470	72,140	1,852
011		DIETARY	291,136	3,733	2,615	41,014	338,498	68,889	4,865
012		CAFETERIA	88,584	3,974	2,784	11,527	106,869	21,749	5,178
014		NURSING ADMINISTRATION	220,949	1,028	720	52,476	275,173	56,002	1,339
017		MEDICAL RECORDS & LIBRARY	254,584	8,879	6,220	54,193	323,876	65,913	11,570
018		SOCIAL SERVICE	68,860	1,284	900	16,353	87,397	17,787	1,674
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	1,139,096	117,202	82,109	278,012	1,616,419	328,964	152,727
026		INTENSIVE CARE UNIT	231,557	10,701	7,497	57,004	306,759	62,430	13,945
033		NURSERY	10,282	2,721	1,907	2,597	17,507	3,563	3,546
034		SKILLED NURSING FACILITY	598,013	68,663	48,104	135,694	850,474	173,083	89,476
035		NURSING FACILITY	3,588,462				3,588,462		
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	762,671	52,118	36,513	237,822	1,089,124	221,652	67,915
039		DELIVERY ROOM & LABOR ROO	3,183			804	3,987	811	
041		RADIOLOGY-DIAGNOSTIC	1,336,161	36,752	25,748	104,177	1,502,838	305,849	47,892
044		LABORATORY	1,691,842	18,207	12,756	184,483	1,907,288	388,167	23,726
049		RESPIRATORY THERAPY	155,459	13,519	9,471	24,744	203,193	41,353	17,617
050		PHYSICAL THERAPY	650,543	28,973	20,298	150,882	850,696	173,129	37,755
053		ELECTROCARDIOLOGY	34,639			8,750	43,389	8,830	
055		MEDICAL SUPPLIES CHARGED	751,852	14,258	9,989	10,894	786,993	160,164	18,579
056		DRUGS CHARGED TO PATIENTS	1,319,834	21,900	15,343	54,078	1,411,155	287,190	28,539
059		PSYCHIATRIC/PSYCHOLOGICAL	308,484	13,929	9,758	45,942	378,113	76,951	18,151
		OUTPAT SERVICE COST CNTRS							
061		EMERGENCY	1,008,038	18,641	13,060	138,982	1,178,721	239,886	24,291
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	575,387	11,512	8,065	121,762	716,726	145,864	15,002
		OTHER REIMBURS CDST CNTRS							
071		HOME HEALTH AGENCY	348,365	15,414	10,799	70,520	445,098	90,584	20,086
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	23,285,909	562,883	394,346	2,121,588	23,073,914	3,253,896	638,469
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
100		DR. OFFICE	982,193	17,260	12,092	182,643	1,194,188	243,034	22,492
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	24,268,102	580,143	406,438	2,304,231	24,268,102	3,496,930	660,961

COST ALLOCATION - GENERAL SERVICE COSTS | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | PREPARED 12/ 8/2009 | WORKSHEET B PART I

		COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY
			8	9	10	11	12	14	17
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL							
007		MAINTENANCE & REPAIRS							
008		OPERATION OF PLANT	518,702						
009		LAUNDRY & LINEN SERVICE	10,817	300,603					
010		HOUSEKEEPING	1,497	8,139	438,098				
011		DIETARY	3,933	4,522	3,402	424,109			
012		CAFETERIA	4,186	4,385	3,622		145,989		
014		NURSING ADMINISTRATION	1,083		937		2,320	336,854	
017		MEDICAL RECORDS & LIBRARY	9,354		8,093		5,856		424,662
018		SOCIAL SERVICE	1,353		1,171		1,492		
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	123,472	79,038	106,819	140,694	17,859	127,101	30,770
026		INTENSIVE CARE UNIT	11,274	6,896	9,754	18,455	2,883	20,518	4,730
033		NURSERY	2,867	11,371	2,480		217	1,545	241
034		SKILLED NURSING FACILITY	72,337	127,518	62,582	264,960	11,527	82,038	6,467
035		NURSING FACILITY					52,956		
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	54,906	24,733	47,502		6,487	46,166	26,466
039		DELIVERY ROOM & LABOR ROO		11,371			67	478	
041		RADIOLOGY-DIAGNOSTIC	38,719		33,497		6,199		111,937
044		LABORATORY	19,182		16,595		12,234		70,455
049		RESPIRATORY THERAPY	14,243		12,322		1,703		21,290
050		PHYSICAL THERAPY	30,523	9,789	26,407		8,224		22,198
053		ELECTROCARDIOLOGY					602		7,375
055		MEDICAL SUPPLIES CHARGED	15,021		12,995		1,277		30,148
056		DRUGS CHARGED TO PATIENTS	23,072		19,961		2,702		52,277
059		PSYCHIATRIC/PSYCHOLOGICAL	14,674		12,695				12,203
		OUTPAT SERVICE COST CNTRS							
061		EMERGENCY	19,638	12,841	16,990		8,291	59,008	15,746
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	12,128		10,493		1,237		5,532
		OTHER REIMBURS COST CNTRS							
071		HOME HEALTH AGENCY	16,239		14,049				
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	500,518	300,603	422,366	424,109	144,133	336,854	417,835
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
100		DR. OFFICE	18,184		15,732		1,856		6,827
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	518,702	300,603	438,098	424,109	145,989	336,854	424,662

	COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
		18	25	26	27
	GENERAL SERVICE COST CNTR				
003	NEW CAP REL COSTS-BLDG &				
004	NEW CAP REL COSTS-MVBLE E				
005	EMPLOYEE BENEFITS				
006	ADMINISTRATIVE & GENERAL				
007	MAINTENANCE & REPAIRS				
008	OPERATION OF PLANT				
009	LAUNDRY & LINEN SERVICE				
010	HOUSEKEEPING				
011	DIETARY				
012	CAFETERIA				
014	NURSING ADMINISTRATION				
017	MEDICAL RECORDS & LIBRARY				
018	SOCIAL SERVICE	110,874			
	INPAT ROUTINE SRVC CNTRS				
025	ADULTS & PEDIATRICS	110,874	2,834,737		2,834,737
026	INTENSIVE CARE UNIT		457,644		457,644
033	NURSERY		43,337		43,337
034	SKILLED NURSING FACILITY		1,740,462		1,740,462
035	NURSING FACILITY		3,641,418		3,641,418
	ANCILLARY SRVC COST CNTRS				
037	OPERATING ROOM		1,584,951		1,584,951
039	DELIVERY ROOM & LABOR ROO		16,714		16,714
041	RADIOLOGY-DIAGNOSTIC		2,046,931		2,046,931
044	LABORATORY		2,437,647		2,437,647
049	RESPIRATORY THERAPY		311,721		311,721
050	PHYSICAL THERAPY		1,158,721		1,158,721
053	ELECTROCARDIOLOGY		60,196		60,196
055	MEDICAL SUPPLIES CHARGED		1,025,177		1,025,177
056	DRUGS CHARGED TO PATIENTS		1,824,896		1,824,896
059	PSYCHIATRIC/PSYCHOLOGICAL		512,787		512,787
	OUTPAT SERVICE COST CNTRS				
061	EMERGENCY		1,575,412		1,575,412
062	OBSERVATION BEDS (NON-DIS				
063	OTHER OUTPATIENT SERVICE				
063 50	RURAL HEALTH CLINIC		906,982		906,982
	OTHER REIMBURS COST CNTRS				
071	HOME HEALTH AGENCY		586,056		586,056
	SPEC PURPOSE COST CENTERS				
095	SUBTOTALS	110,874	22,765,789		22,765,789
	NONREIMBURS COST CENTERS				
096	GIFT, FLOWER, COFFEE SHOP				
100	DR. OFFICE		1,502,313		1,502,313
101	CROSS FOOT ADJUSTMENT				
102	NEGATIVE COST CENTER				
103	TOTAL	110,874	24,268,102		24,268,102

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET B I PART III

	COST CENTER DESCRIPTION	DIR ASSGNED NEW CAPITAL REL COSTS	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
		0	3	4	4a	5	6	7
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL		50,191	35,163	85,354		85,354	
007	MAINTENANCE & REPAIRS		22,735	15,928	38,663		2,728	41,391
008	OPERATION OF PLANT		14,860	10,411	25,271		2,061	1,213
009	LAUNDRY & LINEN SERVICE		10,268	7,193	17,461		1,141	838
010	HOUSEKEEPING		1,421	995	2,416		1,761	116
011	DIETARY		3,733	2,615	6,348		1,681	305
012	CAFETERIA		3,974	2,784	6,758		531	324
014	NURSING ADMINISTRATION		1,028	720	1,748		1,367	84
017	MEDICAL RECORDS & LIBRARY		8,879	6,220	15,099		1,609	725
018	SOCIAL SERVICE		1,284	900	2,184		434	105
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS		117,202	82,109	199,311		8,029	9,564
026	INTENSIVE CARE UNIT		10,701	7,497	18,198		1,524	873
033	NURSERY		2,721	1,907	4,628		87	222
034	SKILLED NURSING FACILITY		68,663	48,104	116,767		4,224	5,603
035	NURSING FACILITY							
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM		52,118	36,513	88,631		5,410	4,253
039	DELIVERY ROOM & LABOR ROO						20	
041	RADIOLOGY-DIAGNOSTIC		36,752	25,748	62,500		7,465	2,999
044	LABORATORY		18,207	12,756	30,963		9,478	1,486
049	RESPIRATORY THERAPY		13,519	9,471	22,990		1,009	1,103
050	PHYSICAL THERAPY		28,973	20,298	49,271		4,225	2,364
053	ELECTROCARDIOLOGY						216	
055	MEDICAL SUPPLIES CHARGED		14,258	9,989	24,247		3,909	1,163
056	DRUGS CHARGED TO PATIENTS		21,900	15,343	37,243		7,009	1,787
059	PSYCHIATRIC/PSYCHOLOGICAL		13,929	9,758	23,687		1,878	1,137
	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY		18,641	13,060	31,701		5,855	1,521
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063 50	RURAL HEALTH CLINIC		11,512	8,065	19,577		3,560	939
	OTHER REIMBURS COST CNTRS							
071	HOME HEALTH AGENCY		15,414	10,799	26,213		2,211	1,258
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS		562,883	394,346	957,229		79,422	39,982
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP							
100	DR. OFFICE		17,260	12,092	29,352		5,932	1,409
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL		580,143	406,438	986,581		85,354	41,391

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL RECOR DS & LIBRARY
		8	9	10	11	12	14	17
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL							
007	MAINTENANCE & REPAIRS							
008	OPERATION OF PLANT	28,545						
009	LAUNDRY & LINEN SERVICE	595	20,035					
010	HOUSEKEEPING	82	542	4,917				
011	DIETARY	216	301	38	8,889			
012	CAFETERIA	230	292	41		8,176		
014	NURSING ADMINISTRATION	60		11		130	3,400	
017	MEDICAL RECORDS & LIBRARY	515		91		328		18,367
018	SOCIAL SERVICE	74		13		84		
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	6,793	5,268	1,199	2,949	1,000	1,282	1,332
026	INTENSIVE CARE UNIT	620	460	109	387	161	207	205
033	NURSERY	158	758	28		12	16	10
034	SKILLED NURSING FACILITY	3,981	8,500	702	5,553	646	828	280
035	NURSING FACILITY					2,966		
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	3,022	1,648	533		363	466	1,145
039	DELIVERY ROOM & LABOR ROO		758			4	5	
041	RADIOLOGY-DIAGNOSTIC	2,131		376		347		4,834
044	LABORATORY	1,056		186		685		3,049
049	RESPIRATORY THERAPY	784		138		95		921
050	PHYSICAL THERAPY	1,680	652	296		461		961
053	ELECTROCARDIOLOGY					34		319
055	MEDICAL SUPPLIES CHARGED	827		146		72		1,305
056	DRUGS CHARGED TO PATIENTS	1,270		224		151		2,263
059	PSYCHIATRIC/PSYCHOLOGICAL	808		142				528
	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY	1,081	856	191		464	596	681
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063 50	RURAL HEALTH CLINIC	667		118		69		239
	OTHER REIMBURS COST CNTRS							
071	HOME HEALTH AGENCY	894		158				
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	27,544	20,035	4,740	8,889	8,072	3,400	18,072
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP							
100	DR. OFFICE	1,001		177		104		295
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	28,545	20,035	4,917	8,889	8,176	3,400	18,367

	COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		18	25	26	27
	GENERAL SERVICE COST CNTR				
003	NEW CAP REL COSTS-BLDG &				
004	NEW CAP REL COSTS-MVBLE E				
005	EMPLOYEE BENEFITS				
006	ADMINISTRATIVE & GENERAL				
007	MAINTENANCE & REPAIRS				
008	OPERATION OF PLANT				
009	LAUNDRY & LINEN SERVICE				
010	HOUSEKEEPING				
011	DIETARY				
012	CAFETERIA				
014	NURSING ADMINISTRATION				
017	MEDICAL RECORDS & LIBRARY				
018	SOCIAL SERVICE	2,894			
	INPAT ROUTINE SRVC CNTRS				
025	ADULTS & PEDIATRICS	2,894	239,621		239,621
026	INTENSIVE CARE UNIT		22,744		22,744
033	NURSERY		5,919		5,919
034	SKILLED NURSING FACILITY		147,084		147,084
035	NURSING FACILITY		2,966		2,966
	ANCILLARY SRVC COST CNTRS				
037	OPERATING ROOM		105,471		105,471
039	DELIVERY ROOM & LABOR ROO		787		787
041	RADIOLOGY-DIAGNOSTIC		80,652		80,652
044	LABORATORY		46,903		46,903
049	RESPIRATORY THERAPY		27,040		27,040
050	PHYSICAL THERAPY		59,910		59,910
053	ELECTROCARDIOLOGY		569		569
055	MEDICAL SUPPLIES CHARGED		31,669		31,669
056	DRUGS CHARGED TO PATIENTS		49,947		49,947
059	PSYCHIATRIC/PSYCHOLOGICAL		28,180		28,180
	OUTPAT SERVICE COST CNTRS				
061	EMERGENCY		42,946		42,946
062	OBSERVATION BEDS (NON-DIS				
063	OTHER OUTPATIENT SERVICE				
063 50	RURAL HEALTH CLINIC		25,169		25,169
	OTHER REIMBURS COST CNTRS				
071	HOME HEALTH AGENCY		30,734		30,734
	SPEC PURPOSE COST CENTERS				
095	SUBTOTALS	2,894	948,311		948,311
	NONREIMBURS COST CENTERS				
096	GIFT, FLOWER, COFFEE SHOP				
100	DR. OFFICE		38,270		38,270
101	CROSS FOOT ADJUSTMENTS				
102	NEGATIVE COST CENTER				
103	TOTAL	2,894	986,581		986,581

		COST CENTER DESCRIPTION	NEW CAP REL COSTS-BLDG & (SQUARE FEET)	NEW CAP REL COSTS-MVBLE E (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS LARIES)	SA RECONCILIATION	ADMINISTRATIV E & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)
			3	4	5	6a.00	6	7
		GENERAL SERVICE COST						
003		NEW CAP REL COSTS-BLD	72,265					
004		NEW CAP REL COSTS-MVB		72,265				
005		EMPLOYEE BENEFITS			9,122,318			
006		ADMINISTRATIVE & GENE	6,252	6,252	851,179	-3,496,930	17,182,710	
007		MAINTENANCE & REPAIRS	2,832	2,832	207,475		549,193	63,181
008		OPERATION OF PLANT	1,851	1,851			414,900	1,851
009		LAUNDRY & LINEN SERVI	1,279	1,279			229,666	1,279
010		HOUSEKEEPING	177	177	203,764		354,470	177
011		DIETARY	465	465	162,372		338,498	465
012		CAFETERIA	495	495	45,635		106,869	495
014		NURSING ADMINISTRATIO	128	128	207,750		275,173	128
017		MEDICAL RECORDS & LIB	1,106	1,106	214,545		323,876	1,106
018		SOCIAL SERVICE	160	160	64,741		87,397	160
		INPAT ROUTINE SRVC CN						
025		ADULTS & PEDIATRICS	14,599	14,599	1,100,641		1,616,419	14,599
026		INTENSIVE CARE UNIT	1,333	1,333	225,674		306,759	1,333
033		NURSERY	339	339	10,282		17,507	339
034		SKILLED NURSING FACIL	8,553	8,553	537,205		850,474	8,553
035		NURSING FACILITY				-3,588,462		
		ANCILLARY SRVC COST C						
037		OPERATING ROOM	6,492	6,492	941,524		1,089,124	6,492
039		DELIVERY ROOM & LABOR			3,183		3,987	
041		RADIOLOGY-DIAGNOSTIC	4,578	4,578	412,430		1,502,838	4,578
044		LABORATORY	2,268	2,268	730,358		1,907,288	2,268
049		RESPIRATORY THERAPY	1,684	1,684	97,960		203,193	1,684
050		PHYSICAL THERAPY	3,609	3,609	597,332		850,696	3,609
053		ELECTROCARDIOLOGY			34,639		43,389	
055		MEDICAL SUPPLIES CHAR	1,776	1,776	43,130		786,993	1,776
056		DRUGS CHARGED TO PATI	2,728	2,728	214,092		1,411,155	2,728
059		PSYCHIATRIC/PSYCHOLOG	1,735	1,735	181,881		378,113	1,735
		OUTPAT SERVICE COST C						
061		EMERGENCY	2,322	2,322	550,221		1,178,721	2,322
062		OBSERVATION BEDS (NON						
063		OTHER OUTPATIENT SERV						
063	50	RURAL HEALTH CLINIC	1,434	1,434	482,048		716,726	1,434
		OTHER REIMBURS COST C						
071		HOME HEALTH AGENCY	1,920	1,920	279,185		445,098	1,920
		SPEC PURPOSE COST CEN						
095		SUBTOTALS	70,115	70,115	8,399,246	-7,085,392	15,988,522	61,031
		NONREIMBURS COST CENT						
096		GIFT, FLOWER, COFFEE						
100		DR. OFFICE	2,150	2,150	723,072		1,194,188	2,150
101		CROSS FOOT ADJUSTMENT						
102		NEGATIVE COST CENTER						
103		COST TO BE ALLOCATED (WRKSHT B, PART I)	580,143	406,438	2,304,231		3,496,930	660,961
104		UNIT COST MULTIPLIER (WRKSHT B, PT I)	8.027994	5.624272	.252593		.203514	10.461389
105		COST TO BE ALLOCATED (WRKSHT B, PART II)						
106		UNIT COST MULTIPLIER (WRKSHT B, PT II)						
107		COST TO BE ALLOCATED (WRKSHT B, PART III					85,354	41,391
108		UNIT COST MULTIPLIER (WRKSHT B, PT III)					.004967	.655118

	COST CENTER DESCRIPTION	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PAID HOURS)	NURSING ADMINISTRATION (DIRECT NSING HRS)	MEDICAL RECORDS & LIBRARY (GROSS REV)
		8	9	10	11	12	14	17
	GENERAL SERVICE COST							
003	NEW CAP REL COSTS-BLD							
004	NEW CAP REL COSTS-MVB							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENE							
007	MAINTENANCE & REPAIRS							
008	OPERATION OF PLANT	61,330						
009	LAUNDRY & LINEN SERVI	1,279	199,703					
010	HOUSEKEEPING	177	5,407	59,874				
011	DIETARY	465	3,004	465	42,699			
012	CAFETERIA	495	2,913	495		452,009		
014	NURSING ADMINISTRATIO	128		128		7,182	146,545	
017	MEDICAL RECORDS & LIB	1,106		1,106		18,132		47,007,695
018	SOCIAL SERVICE	160		160		4,621		
	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	14,599	52,508	14,599	14,165	55,294	55,294	3,406,053
026	INTENSIVE CARE UNIT	1,333	4,581	1,333	1,858	8,926	8,926	523,610
033	NURSERY	339	7,554	339		672	672	26,660
034	SKILLED NURSING FACIL	8,553	84,717	8,553	26,676	35,690	35,690	715,897
035	NURSING FACILITY					163,960		
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	6,492	16,431	6,492		20,084	20,084	2,929,604
039	DELIVERY ROOM & LABOR		7,554			208	208	
041	RADIOLOGY-DIAGNOSTIC	4,578		4,578		19,193		12,391,144
044	LABORATORY	2,268		2,268		37,878		7,798,906
049	RESPIRATORY THERAPY	1,684		1,684		5,274		2,356,688
050	PHYSICAL THERAPY	3,609	6,503	3,609		25,462		2,457,107
053	ELECTROCARDIOLOGY					1,865		816,332
055	MEDICAL SUPPLIES CHAR	1,776		1,776		3,953		3,337,166
056	DRUGS CHARGED TO PATI	2,728		2,728		8,367		5,786,698
059	PSYCHIATRIC/PSYCHOLOG	1,735		1,735				1,350,841
	OUTPAT SERVICE COST C							
061	EMERGENCY	2,322	8,531	2,322		25,671	25,671	1,742,923
062	OBSERVATION BEDS (NON							
063	OTHER OUTPATIENT SERV							
063 50	RURAL HEALTH CLINIC	1,434		1,434		3,831		612,367
	OTHER REIMBURS COST C							
071	HOME HEALTH AGENCY	1,920		1,920				
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	59,180	199,703	57,724	42,699	446,263	146,545	46,251,996
	NONREIMBURS COST CENT							
096	GIFT, FLOWER, COFFEE							
100	DR. OFFICE	2,150		2,150		5,746		755,699
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	518,702	300,603	438,098	424,109	145,989	336,854	424,662
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	8.457557	1.505250	7.316999	9.932528	.322978	2.298639	.009034
105	COST TO BE ALLOCATED (WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)							
107	COST TO BE ALLOCATED (WRKSHT B, PART III	28,545	20,035	4,917	8,889	8,176	3,400	18,367
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	.465433	.100324	.082122	.208178	.018088	.023201	.000391

	COST CENTER DESCRIPTION	SOCIAL SERVICE (TIME SPENT)
		18
	GENERAL SERVICE COST	
003	NEW CAP REL COSTS-BLD	
004	NEW CAP REL COSTS-MVB	
005	EMPLOYEE BENEFITS	
006	ADMINISTRATIVE & GENE	
007	MAINTENANCE & REPAIRS	
008	OPERATION OF PLANT	
009	LAUNDRY & LINEN SERVI	
010	HOUSEKEEPING	
011	DIETARY	
012	CAFETERIA	
014	NURSING ADMINISTRATIO	
017	MEDICAL RECORDS & LIB	
018	SOCIAL SERVICE	100
	INPAT ROUTINE SRVC CN	
025	ADULTS & PEDIATRICS	100
026	INTENSIVE CARE UNIT	
033	NURSERY	
034	SKILLED NURSING FACIL	
035	NURSING FACILITY	
	ANCILLARY SRVC COST C	
037	OPERATING ROOM	
039	DELIVERY ROOM & LABOR	
041	RADIOLOGY-DIAGNOSTIC	
044	LABORATORY	
049	RESPIRATORY THERAPY	
050	PHYSICAL THERAPY	
053	ELECTROCARDIOLOGY	
055	MEDICAL SUPPLIES CHAR	
056	DRUGS CHARGED TO PATI	
059	PSYCHIATRIC/PSYCHOLOG	
	OUTPAT SERVICE COST C	
061	EMERGENCY	
062	OBSERVATION BEDS (NON	
063	OTHER OUTPATIENT SERV	
063 50	RURAL HEALTH CLINIC	
	OTHER REIMBURS COST C	
071	HOME HEALTH AGENCY	
	SPEC PURPOSE COST CEN	
095	SUBTOTALS	100
	NONREIMBURS COST CENT	
096	GIFT, FLOWER, COFFEE	
100	DR. OFFICE	
101	CROSS FOOT ADJUSTMENT	
102	NEGATIVE COST CENTER	
103	COST TO BE ALLOCATED (PER WRKSHT B, PART	110,874
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	1,108.740000
105	COST TO BE ALLOCATED (PER WRKSHT B, PART	
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)	
107	COST TO BE ALLOCATED (PER WRKSHT B, PART	2,894
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	28.940000

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(05/1999)

COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | PREPARED 12/ 8/2009 | WORKSHEET C PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27	THERAPY ADJUSTMENT	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS
		1	2	3	4	5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	2,834,737		2,834,737		2,834,737
26	INTENSIVE CARE UNIT	457,644		457,644		457,644
33	NURSERY	43,337		43,337		43,337
34	SKILLED NURSING FACILITY	1,740,462		1,740,462		1,740,462
35	NURSING FACILITY	3,641,418		3,641,418		3,641,418
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,584,951		1,584,951		1,584,951
39	DELIVERY ROOM & LABOR ROO	16,714		16,714		16,714
41	RADIOLOGY-DIAGNOSTIC	2,046,931		2,046,931		2,046,931
44	LABORATORY	2,437,647		2,437,647		2,437,647
49	RESPIRATORY THERAPY	311,721		311,721		311,721
50	PHYSICAL THERAPY	1,158,721		1,158,721		1,158,721
53	ELECTROCARDIOLOGY	60,196		60,196		60,196
55	MEDICAL SUPPLIES CHARGED	1,025,177		1,025,177		1,025,177
56	DRUGS CHARGED TO PATIENTS	1,824,896		1,824,896		1,824,896
59	PSYCHIATRIC/PSYCHOLOGICAL	512,787		512,787		512,787
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	1,575,412		1,575,412		1,575,412
62	OBSERVATION BEDS (NON-DIS	523,121		523,121		523,121
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	906,982		906,982		906,982
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	22,702,854		22,702,854		22,702,854
102	LESS OBSERVATION BEDS	523,121		523,121		523,121
103	TOTAL	22,179,733		22,179,733		22,179,733

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET C I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR DTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	2,845,479		2,845,479			
26	INTENSIVE CARE UNIT	523,610		523,610			
33	NURSERY	26,660		26,660			
34	SKILLED NURSING FACILITY	715,897		715,897			
35	NURSING FACILITY	5,379,937		5,379,937			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	562,202	2,367,402	2,929,604	.541012	.541012	.541012
39	DELIVERY ROOM & LABOR ROO						
41	RADIOLOGY-DIAGNOSTIC	1,778,543	10,612,601	12,391,144	.165193	.165193	.165193
44	LABORATORY	1,904,715	5,894,191	7,798,906	.312563	.312563	.312563
49	RESPIRATORY THERAPY	514,505	883,606	1,398,111	.222959	.222959	.222959
50	PHYSICAL THERAPY	1,001,435	1,455,672	2,457,107	.471579	.471579	.471579
53	ELECTROCARDIOLOGY	276,300	540,032	816,332	.073740	.073740	.073740
55	MEDICAL SUPPLIES CHARGED	1,942,276	2,353,467	4,295,743	.238650	.238650	.238650
56	DRUGS CHARGED TO PATIENTS	2,759,377	3,027,321	5,786,698	.315361	.315361	.315361
59	PSYCHIATRIC/PSYCHOLOGICAL		1,350,841	1,350,841	.379606	.379606	.379606
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	202,724	1,540,199	1,742,923	.903891	.903891	.903891
62	OBSERVATION BEDS (NON-DIS	35,449	525,125	560,574	.933188	.933188	.933188
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC		612,367	612,367	1.481109	1.481109	1.481109
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	20,469,109	31,162,824	51,631,933			
102	LESS OBSERVATION BEDS						
103	TOTAL	20,469,109	31,162,824	51,631,933			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET C I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27	THERAPY ADJUSTMENT	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS
		1	2	3	4	5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	2,834,737		2,834,737		2,834,737
26	INTENSIVE CARE UNIT	457,644		457,644		457,644
33	NURSERY	43,337		43,337		43,337
34	SKILLED NURSING FACILITY	1,740,462		1,740,462		1,740,462
35	NURSING FACILITY	3,641,418		3,641,418		3,641,418
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,584,951		1,584,951		1,584,951
39	DELIVERY ROOM & LABOR ROO	16,714		16,714		16,714
41	RADIOLOGY-DIAGNOSTIC	2,046,931		2,046,931		2,046,931
44	LABORATORY	2,437,647		2,437,647		2,437,647
49	RESPIRATORY THERAPY	311,721		311,721		311,721
50	PHYSICAL THERAPY	1,158,721		1,158,721		1,158,721
53	ELECTROCARDIOLOGY	60,196		60,196		60,196
55	MEDICAL SUPPLIES CHARGED	1,025,177		1,025,177		1,025,177
56	DRUGS CHARGED TO PATIENTS	1,824,896		1,824,896		1,824,896
59	PSYCHIATRIC/PSYCHOLOGICAL	512,787		512,787		512,787
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	1,575,412		1,575,412		1,575,412
62	OBSERVATION BEDS (NON-DIS	523,121		523,121		523,121
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	906,982		906,982		906,982
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	22,702,854		22,702,854		22,702,854
102	LESS OBSERVATION BEDS	523,121		523,121		523,121
103	TOTAL	22,179,733		22,179,733		22,179,733

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET C I PART I

WKST A LINE NO.		COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
		INPAT ROUTINE SRVC CNTRS						
25		ADULTS & PEDIATRICS	2,845,479		2,845,479			
26		INTENSIVE CARE UNIT	523,610		523,610			
33		NURSERY	26,660		26,660			
34		SKILLED NURSING FACILITY	715,897		715,897			
35		NURSING FACILITY	5,379,937		5,379,937			
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	562,202	2,367,402	2,929,604	.541012	.541012	.541012
39		DELIVERY ROOM & LABOR ROO						
41		RADIOLOGY-DIAGNOSTIC	1,778,543	10,612,601	12,391,144	.165193	.165193	.165193
44		LABORATORY	1,904,715	5,894,191	7,798,906	.312563	.312563	.312563
49		RESPIRATORY THERAPY	514,505	883,606	1,398,111	.222959	.222959	.222959
50		PHYSICAL THERAPY	1,001,435	1,455,672	2,457,107	.471579	.471579	.471579
53		ELECTROCARDIOLOGY	276,300	540,032	816,332	.073740	.073740	.073740
55		MEDICAL SUPPLIES CHARGED	1,942,276	2,353,467	4,295,743	.238650	.238650	.238650
56		DRUGS CHARGED TO PATIENTS	2,759,377	3,027,321	5,786,698	.315361	.315361	.315361
59		PSYCHIATRIC/PSYCHOLOGICAL		1,350,841	1,350,841	.379606	.379606	.379606
		OUTPAT SERVICE COST CNTRS						
61		EMERGENCY	202,724	1,540,199	1,742,923	.903891	.903891	.903891
62		OBSERVATION BEDS (NON-DIS	35,449	525,125	560,574	.933188	.933188	.933188
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC		612,367	612,367	1.481109	1.481109	1.481109
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	20,469,109	31,162,824	51,631,933			
102		LESS OBSERVATION BEDS						
103		TOTAL	20,469,109	31,162,824	51,631,933			

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | PREPARED 12/ 8/2009 | WORKSHEET C PART II

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	1,584,951	105,471	1,479,480			1,584,951
39		DELIVERY ROOM & LABOR ROO	16,714	787	15,927			16,714
41		RADIOLOGY-DIAGNOSTIC	2,046,931	80,652	1,966,279			2,046,931
44		LABORATORY	2,437,647	46,903	2,390,744			2,437,647
49		RESPIRATORY THERAPY	311,721	27,040	284,681			311,721
50		PHYSICAL THERAPY	1,158,721	59,910	1,098,811			1,158,721
53		ELECTROCARDIOLOGY	60,196	569	59,627			60,196
55		MEDICAL SUPPLIES CHARGED	1,025,177	31,669	993,508			1,025,177
56		DRUGS CHARGED TO PATIENTS	1,824,896	49,947	1,774,949			1,824,896
59		PSYCHIATRIC/PSYCHOLOGICAL	512,787	28,180	484,607			512,787
		OUTPAT SERVICE COST CNTRS						
61		EMERGENCY	1,575,412	42,946	1,532,466			1,575,412
62		OBSERVATION BEDS (NON-DIS	523,121		523,121			523,121
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	906,982	25,169	881,813			906,982
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	13,985,256	499,243	13,486,013			13,985,256
102		LESS OBSERVATION BEDS	523,121		523,121			523,121
103		TOTAL	13,462,135	499,243	12,962,892			13,462,135

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
			7	8	9
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	2,929,604	.541012	.541012
39		DELIVERY ROOM & LABOR ROO			
41		RADIOLOGY-DIAGNOSTIC	12,391,144	.165193	.165193
44		LABORATORY	7,798,906	.312563	.312563
49		RESPIRATORY THERAPY	1,398,111	.222959	.222959
50		PHYSICAL THERAPY	2,457,107	.471579	.471579
53		ELECTROCARDIOLOGY	816,332	.073740	.073740
55		MEDICAL SUPPLIES CHARGED	4,295,743	.238650	.238650
56		DRUGS CHARGED TO PATIENTS	5,786,698	.315361	.315361
59		PSYCHIATRIC/PSYCHOLOGICAL	1,350,841	.379606	.379606
		OUTPAT SERVICE COST CNTRS			
61		EMERGENCY	1,742,923	.903891	.903891
62		OBSERVATION BEDS (NON-DIS	560,574	.933188	.933188
63		OTHER OUTPATIENT SERVICE			
63	50	RURAL HEALTH CLINIC	612,367	1.481109	1.481109
		OTHER REIMBURS COST CNTRS			
101		SUBTOTAL	42,140,350		
102		LESS OBSERVATION BEDS	560,574		
103		TOTAL	41,579,776		

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL **NOT A CMS WORKSHEET ** (09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS SPECIAL TITLE XIX WORKSHEET | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | PREPARED 12/ 8/2009 | WORKSHEET C PART II

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27	CAPITAL COST WKST B PT II & III, COL. 27	OPERATING COST NET OF CAPITAL COST	CAPITAL REDUCTION	OPERATING COST REDUCTION AMOUNT	COST NET OF CAP AND OPER COST REDUCTION
			1	2	3	4	5	6
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	1,584,951	105,471	1,479,480			1,584,951
39		DELIVERY ROOM & LABOR ROO	16,714	787	15,927			16,714
41		RADIOLOGY-DIAGNOSTIC	2,046,931	80,652	1,966,279			2,046,931
44		LABORATORY	2,437,647	46,903	2,390,744			2,437,647
49		RESPIRATORY THERAPY	311,721	27,040	284,681			311,721
50		PHYSICAL THERAPY	1,158,721	59,910	1,098,811			1,158,721
53		ELECTROCARDIOLOGY	60,196	569	59,627			60,196
55		MEDICAL SUPPLIES CHARGED	1,025,177	31,669	993,508			1,025,177
56		DRUGS CHARGED TO PATIENTS	1,824,896	49,947	1,774,949			1,824,896
59		PSYCHIATRIC/PSYCHOLOGICAL	512,787	28,180	484,607			512,787
		OUTPAT SERVICE COST CNTRS						
61		EMERGENCY	1,575,412	42,946	1,532,466			1,575,412
62		OBSERVATION BEDS (NON-DIS	523,121		523,121			523,121
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	906,982	25,169	881,813			906,982
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	13,985,256	499,243	13,486,013			13,985,256
102		LESS OBSERVATION BEDS	523,121		523,121			523,121
103		TOTAL	13,462,135	499,243	12,962,892			13,462,135

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL **NOT A CMS WORKSHEET ** (09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS SPECIAL TITLE XIX WORKSHEET | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | PREPARED 12/ 8/2009 WORKSHEET C PART II

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
			7	8	9
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	2,929,604	.541012	.541012
39		DELIVERY ROOM & LABOR ROO			
41		RADIOLOGY-DIAGNOSTIC	12,391,144	.165193	.165193
44		LABORATORY	7,798,906	.312563	.312563
49		RESPIRATORY THERAPY	1,398,111	.222959	.222959
50		PHYSICAL THERAPY	2,457,107	.471579	.471579
53		ELECTROCARDIOLOGY	816,332	.073740	.073740
55		MEDICAL SUPPLIES CHARGED	4,295,743	.238650	.238650
56		DRUGS CHARGED TO PATIENTS	5,786,698	.315361	.315361
59		PSYCHIATRIC/PSYCHOLOGICAL	1,350,841	.379606	.379606
		OUTPAT SERVICE COST CNTRS			
61		EMERGENCY	1,742,923	.903891	.903891
62		OBSERVATION BEDS (NON-DIS	560,574	.933188	.933188
63		OTHER OUTPATIENT SERVICE			
63	50	RURAL HEALTH CLINIC	612,367	1.481109	1.481109
		OTHER REIMBURS COST CNTRS			
101		SUBTOTAL	42,140,350		
102		LESS OBSERVATION BEDS	560,574		
103		TOTAL	41,579,776		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET C I PART III

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM	698,031	1,358,747			
39		DELIVERY ROOM & LABOR ROO	34,842				
41		RADIOLOGY-DIAGNOSTIC	1,027,971	6,242,107			
44		LABORATORY	1,176,749	3,928,993			
49		RESPIRATORY THERAPY	152,276	681,456			
50		PHYSICAL THERAPY	684,205	1,248,287			
53		ELECTROCARDIOLOGY	27,938	451,100			
55		MEDICAL SUPPLIES CHARGED	448,556	2,063,704			
56		DRUGS CHARGED TO PATIENTS	922,017	2,870,099			
59		PSYCHIATRIC/PSYCHOLOGICAL	255,001	731,014			
		OUTPAT SERVICE COST CNTRS					
61		EMERGENCY	696,130	874,038			
62		OBSERVATION BEDS (NON-DIS	250,063	260,799			
63		OTHER OUTPATIENT SERVICE					
63	50	RURAL HEALTH CLINIC					
		OTHER REIMBURS COST CNTRS					
101		TOTAL	6,373,779	20,710,344			

COMPUTATION OF OUTPATIENT COST PER VISIT - RURAL PRIMARY CARE HOSPITAL

PROVIDER NO: 14-1311 PERIOD: FROM 7/ 1/2008 TO 6/30/2009 PREPARED 12/ 8/2009

WORKSHEET C PART V

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27	PROVIDER-BASED PHYSICIAN ADJUSTMENT	TOTAL COSTS	TOTAL ANCILLARY CHARGES	TOTAL OUTPATIENT CHARGES	RATIO OF OUT-PATIENT CHRGS TO TTL CHARGES	TOTAL OUT-PATIENT COSTS
		1	2	3	4	5	6	7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM	698,031	206,741	904,772	1,358,747			
39	DELIVERY ROOM & LABOR ROO	34,842		34,842				
41	RADIOLOGY-DIAGNOSTIC	1,027,971		1,027,971	6,242,107			
44	LABORATORY	1,176,749		1,176,749	3,928,993			
49	RESPIRATORY THERAPY	152,276		152,276	681,456			
50	PHYSICAL THERAPY	684,205		684,205	1,248,287			
53	ELECTROCARDIOLOGY	27,938	15,503	43,441	451,100			
55	MEDICAL SUPPLIES CHARGED	448,556		448,556	2,063,704			
56	DRUGS CHARGED TO PATIENTS	922,017		922,017	2,870,099			
59	PSYCHIATRIC/PSYCHOLOGICAL	255,001		255,001	731,014			
	OUTPAT SERVICE COST CNTRS							
61	EMERGENCY	696,130	435,080	1,131,210	874,038			
62	OBSERVATION BEDS (NON-DIS	250,063		250,063	260,799			
63	OTHER OUTPATIENT SERVICE							
63 50	RURAL HEALTH CLINIC							
	OTHER REIMBURS COST CNTRS							
101	TOTAL	6,373,779	657,324	7,031,103	20,710,344			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | PREPARED 12/ 8/2009 | WORKSHEET D PART V

COMPONENT NO: 14-1311

TITLE XVIII, PART B HOSPITAL

		Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy
	Cost Center Description	1	1.01	1.02	2	3
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.541012		.541012		
39	DELIVERY ROOM & LABOR ROOM					
41	RADIOLOGY-DIAGNOSTIC	.165193		.165193		
44	LABORATORY	.312563		.312563		
49	RESPIRATORY THERAPY	.222959		.222959		
50	PHYSICAL THERAPY	.471579		.471579		
53	ELECTROCARDIOLOGY	.073740		.073740		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.238650		.238650		
56	DRUGS CHARGED TO PATIENTS	.315361		.315361		
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	.379606		.379606		
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	.903891		.903891		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.933188		.933188		
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET D PART V

I COMPONENT NO: 14-1311 I

TITLE XVIII, PART B HOSPITAL

		Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	Cost Center Description	4	5	6	7	8
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		630,175			
39	DELIVERY ROOM & LABOR ROOM					
41	RADIOLOGY-DIAGNOSTIC		4,044,460			
44	LABORATORY		2,173,778			
49	RESPIRATORY THERAPY		311,386			
50	PHYSICAL THERAPY		598,840			
53	ELECTROCARDIOLOGY		198,154			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,038,040			
56	DRUGS CHARGED TO PATIENTS		1,131,992			
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		1,336,445			
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY		348,676			
62	OBSERVATION BEDS (NON-DISTINCT PART)		369,710			
63	OTHER OUTPATIENT SERVICE COST CENTER					
63	50 RURAL HEALTH CLINIC					
101	SUBTOTAL		12,181,656			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES		12,181,656			

(A) WORKSHEET A LINE NUMBERS

(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | COMPONENT NO: 14-1311 | PREPARED 12/ 8/2009 | WORKSHEET D PART V

TITLE XVIII, PART B HOSPITAL

		Cost Center Description	All Other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
			9	10	11
(A)		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	340,932		
39		DELIVERY ROOM & LABOR ROOM			
41		RADIOLOGY-DIAGNOSTIC	668,116		
44		LABORATORY	679,443		
49		RESPIRATORY THERAPY	69,426		
50		PHYSICAL THERAPY	282,400		
53		ELECTROCARDIOLOGY	14,612		
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	247,728		
56		DRUGS CHARGED TO PATIENTS	356,986		
59		PSYCHIATRIC/PSYCHOLOGICAL SERVICES	507,323		
		OUTPAT SERVICE COST CNTRS			
61		EMERGENCY	315,165		
62		OBSERVATION BEDS (NON-DISTINCT PART)	345,009		
63		OTHER OUTPATIENT SERVICE COST CENTER			
63	50	RURAL HEALTH CLINIC			
101		SUBTOTAL	3,827,140		
102		CRNA CHARGES			
103		LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES			
104		NET CHARGES	3,827,140		

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST

PROVIDER NO:	PERIOD:		PREPARED 12/ 8/2009
14-1311	FROM 7/ 1/2008		WORKSHEET D
COMPONENT NO:	TO 6/30/2009		PART VI
14-1311			

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

		1
1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	.315361
2	PROGRAM VACCINE CHARGES	380
3	PROGRAM COSTS	120

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1996)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009
I COMPONENT NO: 14-5552 I WORKSHEET D PART II

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A LINE NO.		COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPAT PROGRAM CHARGES 4	OLD CAPITAL CST/CHRG RATIO 5	COSTS 6
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM						
39		DELIVERY ROOM & LABOR ROO						
41		RADIOLOGY-DIAGNOSTIC						
44		LABORATORY						
49		RESPIRATORY THERAPY						
50		PHYSICAL THERAPY						
53		ELECTROCARDIOLOGY						
55		MEDICAL SUPPLIES CHARGED						
56		DRUGS CHARGED TO PATIENTS						
59		PSYCHIATRIC/PSYCHOLOGICAL						
		OUTPAT SERVICE COST CNTRS						
61		EMERGENCY						
62		OBSERVATION BEDS (NON-DIS						
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC						
		OTHER REIMBURS COST CNTRS						
101		TOTAL						

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

PROVIDER NO:	PERIOD:		PREPARED 12/ 8/2009
14-1311	FROM 7/ 1/2008		WORKSHEET D
COMPONENT NO:	TO 6/30/2009		PART II
14-5552			

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A LINE NO.		COST CENTER DESCRIPTION	NEW CAPITAL CST/CHRG RATIO 7	COSTS 8
		ANCILLARY SRVC COST CNTRS		
37		OPERATING ROOM		
39		DELIVERY ROOM & LABOR ROO		
41		RADIOLOGY-DIAGNOSTIC		
44		LABORATORY		
49		RESPIRATORY THERAPY		
50		PHYSICAL THERAPY		
53		ELECTROCARDIOLOGY		
55		MEDICAL SUPPLIES CHARGED		
56		DRUGS CHARGED TO PATIENTS		
59		PSYCHIATRIC/PSYCHOLOGICAL		
		OUTPAT SERVICE COST CNTRS		
61		EMERGENCY		
62		OBSERVATION BEDS (NON-DIS		
63		OTHER OUTPATIENT SERVICE		
63	50	RURAL HEALTH CLINIC		
		OTHER REIMBURS COST CNTRS		
101		TOTAL		

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(04/2005)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | PREPARED 12/ 8/2009

COMPONENT NO: 14-5552 | WORKSHEET D PART IV

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	1.01	MED ED NRS SCHOOL COST 2	MED ED ALLIED HEALTH COST 2.01	MED ED ALL OTHER COSTS 2.02	BLOOD CLOT FOR HEMOPHILIACS 2.03
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
39	DELIVERY ROOM & LABOR ROO						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
53	ELECTROCARDIOLOGY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
59	PSYCHIATRIC/PSYCHOLOGICAL						
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM			2,929,604				
39	DELIVERY ROOM & LABOR ROO							
41	RADIOLOGY-DIAGNOSTIC			12,391,144			39,688	
44	LABORATORY			7,798,906			127,873	
49	RESPIRATORY THERAPY			1,398,111			81,609	
50	PHYSICAL THERAPY			2,457,107			692,332	
53	ELECTROCARDIOLOGY			816,332			7,014	
55	MEDICAL SUPPLIES CHARGED			4,295,743			339,032	
56	DRUGS CHARGED TO PATIENTS			5,786,698			149,065	
59	PSYCHIATRIC/PSYCHOLOGICAL			1,350,841				
	OUTPAT SERVICE COST CNTRS							
61	EMERGENCY			1,742,923				
62	OBSERVATION BEDS (NON-DIS			560,574				
63	OTHER OUTPATIENT SERVICE							
63 50	RURAL HEALTH CLINIC							
	OTHER REIMBURS COST CNTRS							
101	TOTAL			41,527,983			1,436,613	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | PREPARED 12/ 8/2009

COMPONENT NO: 14-5552 | WORKSHEET D PART IV

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OUTPAT PROG CHARGES 8	OUTPAT PROG D,V COL 5.03 8.01	OUTPAT PROG D,V COL 5.04 8.02	OUTPAT PROG PASS THRU COST 9	COL 8.01 * COL 5 9.01	COL 8.02 * COL 5 9.02
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
39	DELIVERY ROOM & LABOR ROO						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
53	ELECTROCARDIOLOGY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
59	PSYCHIATRIC/PSYCHOLOGICAL						
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(05/2004)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | PREPARED 12/ 8/2009 | WORKSHEET D PART V

COMPONENT NO: 14-5552

TITLE XVIII, PART B SKILLED NURSING FACILITY

	Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
		1	1.02	2	3	4
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.541012	.541012			
39	DELIVERY ROOM & LABOR ROOM					
41	RADIOLOGY-DIAGNOSTIC	.165193	.165193			
44	LABORATORY	.312563	.312563			
49	RESPIRATORY THERAPY	.222959	.222959			
50	PHYSICAL THERAPY	.471579	.471579			
53	ELECTROCARDIOLOGY	.073740	.073740			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.238650	.238650			
56	DRUGS CHARGED TO PATIENTS	.315361	.315361			
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	.379606	.379606			
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	.903891	.903891			
62	OBSERVATION BEDS (NON-DISTINCT PART)	.933188	.933188			
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | COMPONENT NO: 14-5552 | PREPARED 12/ 8/2009 | WORKSHEET D PART V

TITLE XVIII, PART B SKILLED NURSING FACILITY

	Cost Center Description	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy	Other Outpatient Diagnostic	All Other
		5	6	7	8	9
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM					
39	DELIVERY ROOM & LABOR ROOM					
41	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY					
49	RESPIRATORY THERAPY					
50	PHYSICAL THERAPY					
53	ELECTROCARDIOLOGY					
55	MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	DRUGS CHARGED TO PATIENTS					
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES					
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY					
62	OBSERVATION BEDS (NON-DISTINCT PART)					
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES					

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009
I COMPONENT NO: 14-5552 I WORKSHEET D PART V

TITLE XVIII, PART B SKILLED NURSING FACILITY

(A)	Cost Center Description	Hospital I/P Part B Charges 10	Hospital I/P Part B Costs 11
	ANCILLARY SRVC COST CNTRS		
37	OPERATING ROOM		
39	DELIVERY ROOM & LABOR ROOM		
41	RADIOLOGY-DIAGNOSTIC		
44	LABORATORY		
49	RESPIRATORY THERAPY		
50	PHYSICAL THERAPY		
53	ELECTROCARDIOLOGY		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		
56	DRUGS CHARGED TO PATIENTS		
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		
	OUTPAT SERVICE COST CNTRS		
61	EMERGENCY		
62	OBSERVATION BEDS (NON-DISTINCT PART)		
63	OTHER OUTPATIENT SERVICE COST CENTER		
63 50	RURAL HEALTH CLINIC		
101	SUBTOTAL		
102	CRNA CHARGES		
103	LESS PBP CLINIC LAB SVCS-		
	PROGRAM ONLY CHARGES		
104	NET CHARGES		

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST

PROVIDER NO:	PERIOD:		PREPARED 12/ 8/2009
14-1311	FROM 7/ 1/2008		WORKSHEET D
COMPONENT NO:	TO 6/30/2009		PART VI
14-5552			

TITLE XVIII, PART B SKILLED NURSING FACILITY

PART VI - VACCINE COST APPORTIONMENT

		1
1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	.315361
2	PROGRAM VACCINE CHARGES	
3	PROGRAM COSTS	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | COMPONENT NO: 14-1311 | PREPARED 12/ 8/2009 | WORKSHEET D PART V

TITLE XIX - O/P HOSPITAL

		Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy	Other Outpatient Diagnostic	All Other (1)
	Cost Center Description	1	2	3	4	5
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.541012				579,143
39	DELIVERY ROOM & LABOR ROOM					
41	RADIOLOGY-DIAGNOSTIC	.165193				2,369,345
44	LABORATORY	.312563				941,336
49	RESPIRATORY THERAPY	.222959				146,304
50	PHYSICAL THERAPY	.471579				226,653
53	ELECTROCARDIOLOGY	.073740				85,521
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.238650				523,479
56	DRUGS CHARGED TO PATIENTS	.315361				587,526
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	.379606				
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	.903891				541,439
62	OBSERVATION BEDS (NON-DISTINCT PART)	.933188				
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC	1.481109				
101	SUBTOTAL					6,000,746
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					6,000,746

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET D PART V

I COMPONENT NO: 14-1311 I

TITLE XIX - O/P HOSPITAL

(A)	Cost Center Description	PPS Services FYB to 12/31 5.01	Non-PPS Services 5.02	PPS Services 1/1 to FYE 5.03	Outpatient Ambulatory Surgical Ctr 6	Outpatient Radialogy 7
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM					
39	DELIVERY ROOM & LABOR ROOM					
41	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY					
49	RESPIRATORY THERAPY					
50	PHYSICAL THERAPY					
53	ELECTROCARDIOLOGY					
55	MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	DRUGS CHARGED TO PATIENTS					
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES					
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY					
62	OBSERVATION BEDS (NON-DISTINCT PART)					
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104	NET CHARGES					

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET D PART V

I COMPONENT NO: 14-1311 I

TITLE XIX - O/P HOSPITAL

(A)		Cost Center Description	Other Outpatient Diagnostic 8	All Other 9	PPS Services FYB to 12/31 9.01	Non-PPS Services 9.02	PPS Services 1/1 to FYE 9.03
		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM		313,323			
39		DELIVERY ROOM & LABOR ROOM					
41		RADIOLOGY-DIAGNOSTIC		391,399			
44		LABORATORY		294,227			
49		RESPIRATORY THERAPY		32,620			
50		PHYSICAL THERAPY		106,885			
53		ELECTROCARDIOLOGY		6,306			
55		MEDICAL SUPPLIES CHARGED TO PATIENTS		124,928			
56		DRUGS CHARGED TO PATIENTS		185,283			
59		PSYCHIATRIC/PSYCHOLOGICAL SERVICES					
		OUTPAT SERVICE COST CNTRS					
61		EMERGENCY		489,402			
62		OBSERVATION BEDS (NON-DISTINCT PART)					
63		OTHER OUTPATIENT SERVICE COST CENTER					
63	50	RURAL HEALTH CLINIC					
101		SUBTOTAL		1,944,373			
102		CRNA CHARGES					
103		LESS PBP CLINIC LAB SVCS-					
		PROGRAM ONLY CHARGES					
104		NET CHARGES		1,944,373			

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 12/ 8/2009
14-1311	FROM 7/ 1/2008	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2009	PART I
14-1311		

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	4,010
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,010
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,010
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,282
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,834,737
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,834,737
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,432,713
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,432,713
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.825801
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	856.04
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2,834,737

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:		PREPARED 12/ 8/2009
14-1311	FROM 7/ 1/2008		WORKSHEET D-1
COMPONENT NO:	TO 6/30/2009		PART II
14-1311			

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	706.92
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,613,191
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,613,191

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT	457,644	429	1,066.77	286	305,096
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					

		1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	1,877,952
49	TOTAL PROGRAM INPATIENT COSTS	3,796,239

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
52	TOTAL PROGRAM EXCLUDABLE COST
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES
55	TARGET AMOUNT PER DISCHARGE
56	TARGET AMOUNT
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58	BONUS PAYMENT
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.
58.04	RELIEF PAYMENT
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1
59.03	PROGRAM DISCHARGES AFTER JULY 1
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BEO COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)
62	TOTAL MEDICARE SWING-BEO SNF INPATIENT ROUTINE COSTS
63	TITLE V OR XIX SWING-BEO NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 12/ 8/2009
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14-1311		

TITLE XVIII PART A HOSPITAL OTHER

PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM ROUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	
72	PER DIEM CAPITAL-RELATED COSTS	
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	740
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	706.92
85	OBSERVATION BED COST	523,121

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO: 14-1311	PERIOD: FROM 7/ 1/2008 TO 6/30/2009	PREPARED 12/ 8/2009
COMPONENT NO: 14-5552		WORKSHEET D-1 PART I

TITLE XVIII PART A SNF PPS

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	6,158
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,158
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,158
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,489
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	1,740,462
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,740,462
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	715,897
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	715,897
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	2.431163
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	116.25
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	1,740,462

COMPUTATION OF INPATIENT OPERATING COST

	PROVIDER NO:	PERIOD:	PREPARED 12/ 8/2009
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	14-5552		

TITLE XVIII PART A SNF PPS

PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1,740,462
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	282.63
68	PROGRAM ROUTINE SERVICE COST	703,466
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	703,466
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	147,084
72	PER DIEM CAPITAL-RELATED COSTS	23.89
73	PROGRAM CAPITAL-RELATED COSTS	59,462
74	INPATIENT ROUTINE SERVICE COST	644,004
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	644,004
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	703,466
80	PROGRAM INPATIENT ANCILLARY SERVICES	519,644
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	1,223,110

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	
85	OBSERVATION BED COST	

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

COMPUTATION OF INPATIENT OPERATING COST

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TITLE XIX - I/P HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	4,010
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,010
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,010
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	486
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	42
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,834,737
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,834,737
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,432,713
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,432,713
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.825801
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	856.04
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2,834,737

TITLE XIX - I/P HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

						1
			PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM					706.92
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					343,563
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					343,563
		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)	43,337	42	1,031.83		
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT	457,644	429	1,066.77		
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					
						1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST					462,050
49	TOTAL PROGRAM INPATIENT COSTS					805,613
			PASS THROUGH COST ADJUSTMENTS			
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES					
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES					
52	TOTAL PROGRAM EXCLUDABLE COST					
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS					
			TARGET AMOUNT AND LIMIT COMPUTATION			
54	PROGRAM DISCHARGES					
55	TARGET AMOUNT PER DISCHARGE					
56	TARGET AMOUNT					
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT					
58	BONUS PAYMENT					
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET					
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET					
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.					
58.04	RELIEF PAYMENT					
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT					
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)					
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1					
59.03	PROGRAM DISCHARGES AFTER JULY 1					
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)					
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)					
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)					
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)					
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)					
			PROGRAM INPATIENT ROUTINE SWING BED COST			
60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)					
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)					
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS					
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD					
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD					
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS					

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 12/ 8/2009
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COMPONENT NO:	TO 6/30/2009	PART III
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TITLE XIX - I/P HOSPITAL OTHER

PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM RDUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	
72	PER DIEM CAPITAL-RELATED COSTS	
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	740
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	706.92
85	OBSERVATION BED COST	523,121

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

COMPUTATION OF INPATIENT OPERATING COST

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TITLE XIX - I/P SNF OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	6,158
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,158
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,158
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THRDUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	746,968
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	746,968
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	121.30
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	

TITLE XIX - I/P SNF OTHER

PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM ROUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	147,084
72	PER DIEM CAPITAL-RELATED COSTS	23.89
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	
85	OBSERVATION BED COST	

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 12/ 8/2009
14-1311	FROM 7/ 1/2008	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2009	PART I
14-0000		

TITLE XIX - I/P NF OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	29,456
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	29,456
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	29,456
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF CDST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	23,766
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 DF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,641,418
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,641,418
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	5,379,937
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	5,379,937
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.676851
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	182.64
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	3,641,418

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:		PREPARED 12/ 8/2009
14-1311	FROM 7/ 1/2008		WORKSHEET D-1
COMPONENT NO:	TO 6/30/2009		PART III
14-0000			

TITLE XIX - I/P NF OTHER

PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	3,641,418
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	123.62
68	PROGRAM ROUTINE SERVICE COST	2,937,953
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	2,937,953
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	2,966
72	PER DIEM CAPITAL-RELATED COSTS	.10
73	PROGRAM CAPITAL-RELATED COSTS	2,377
74	INPATIENT ROUTINE SERVICE COST	2,935,576
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	2,935,576
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	2,377
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	2,377

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	
85	OBSERVATION BED COST	

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET D-4 I COMPONENT NO: 14-1311 I

TITLE XVIII, PART A HOSPITAL OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		1,677,270	
26	INTENSIVE CARE UNIT		346,060	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.541012	190,188	102,894
39	DELIVERY ROOM & LABOR ROOM			
41	RADIOLOGY-DIAGNOSTIC	.165193	1,354,261	223,714
44	LABORATORY	.312563	1,402,746	438,446
49	RESPIRATORY THERAPY	.222959	338,333	75,434
50	PHYSICAL THERAPY	.471579	144,413	68,102
53	ELECTROCARDIOLOGY	.073740	194,255	14,324
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.238650	1,060,412	253,067
56	DRUGS CHARGED TO PATIENTS	.315361	1,719,334	542,211
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	.379606		
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.903891	140,149	126,679
62	OBSERVATION BEDS (NON-DISTINCT PART)	.933188	35,449	33,081
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		6,579,540	1,877,952
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		6,579,540	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET D-4

I COMPONENT NO: 14-5552 I I

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.541012		
39	DELIVERY ROOM & LABOR ROOM			
41	RADIOLOGY-DIAGNOSTIC	.165193	39,688	6,556
44	LABORATORY	.312563	127,873	39,968
49	RESPIRATORY THERAPY	.222959	81,609	18,195
50	PHYSICAL THERAPY	.471579	692,332	326,489
53	ELECTROCARDIOLOGY	.073740	7,014	517
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.238650	339,032	80,910
56	DRUGS CHARGED TO PATIENTS	.315361	149,065	47,009
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	.379606		
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.903891		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.933188		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		1,436,613	519,644
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,436,613	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET D-4

I COMPONENT NO: 14-1311 I

TITLE XIX HOSPITAL OTHER

WKST A LINE NO.		COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
		INPAT ROUTINE SRVC CNTRS			
25		ADULTS & PEDIATRICS		495,731	
26		INTENSIVE CARE UNIT		61,710	
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	.541012	141,812	76,722
39		DELIVERY ROOM & LABOR ROOM			
41		RADIOLOGY-DIAGNOSTIC	.165193	167,213	27,622
44		LABORATORY	.312563	187,960	58,749
49		RESPIRATORY THERAPY	.222959	87,271	19,458
50		PHYSICAL THERAPY	.471579	47,789	22,536
53		ELECTROCARDIOLOGY	.073740	13,343	984
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	.238650	510,195	121,758
56		DRUGS CHARGED TO PATIENTS	.315361	340,771	107,466
59		PSYCHIATRIC/PSYCHOLOGICAL SERVICES	.379606		
		OUTPAT SERVICE COST CNTRS			
61		EMERGENCY	.903891	29,600	26,755
62		OBSERVATION BEDS (NON-DISTINCT PART)	.933188		
63		OTHER OUTPATIENT SERVICE COST CENTER			
63	50	RURAL HEALTH CLINIC	1.481109		
		OTHER REIMBURS COST CNTRS			
101		TOTAL		1,525,954	462,050
102		LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103		NET CHARGES		1,525,954	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 12/ 8/2009
14-1311	FROM 7/ 1/2008	WORKSHEET E
COMPONENT NO:	TO 6/30/2009	PART B
14-1311		

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL
1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	3,827,260
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9,02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	3,827,260
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	3,865,533
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	CAH DEDUCTIBLES	56,188
18.01	CAH ACTUAL BILLED COINSURANCE LINE 17.01 (SEE INSTRUCTIONS)	2,008,309
19	SUBTOTAL (SEE INSTRUCTIONS)	1,801,036
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	1,801,036
24	PRIMARY PAYER PAYMENTS	357
25	SUBTOTAL	1,800,679
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	408,042
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	408,042
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	374,177
28	SUBTOTAL	2,208,721
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	2,208,721
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	2,662,687
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	-453,966
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:		PREPARED 12/ 8/2009
14-1311	FROM 7/ 1/2008		WORKSHEET E
COMPONENT NO:	TO 6/30/2009		PART B
14-5552			

PART B - MEDICAL AND OTHER HEALTH SERVICES

		SNF
1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9,02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	
18.01	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	
24	PRIMARY PAYER PAYMENTS	
25	SUBTOTAL	
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
28	SUBTOTAL	
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

PROVIDER NO:	PERIOD:	PREPARED 12/ 8/2009
14-1311	FROM 7/ 1/2008	WORKSHEET E-1
COMPONENT NO:	TO 6/30/2009	
14-1311		

TITLE XVIII HOSPITAL

	DESCRIPTION			INPATIENT-PART A MM/DD/YYYY 1	AMOUNT 2	PART B MM/DD/YYYY 3	AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				3,046,338		2,506,687
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.				NONE		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)						
		ADJUSTMENTS TO PROVIDER	.01	1/ 1/2009	364,800	1/ 1/2009	156,000
		ADJUSTMENTS TO PROVIDER	.02				
		ADJUSTMENTS TO PROVIDER	.03				
		ADJUSTMENTS TO PROVIDER	.04				
		ADJUSTMENTS TO PROVIDER	.05				
		ADJUSTMENTS TO PROGRAM	.50				
		ADJUSTMENTS TO PROGRAM	.51				
		ADJUSTMENTS TO PROGRAM	.52				
		ADJUSTMENTS TO PROGRAM	.53				
		ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL		.99		364,800		156,000
4	TOTAL INTERIM PAYMENTS				3,411,138		2,662,687
	TO BE COMPLETED BY INTERMEDIARY						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)						
		TENTATIVE TO PROVIDER	.01				
		TENTATIVE TO PROVIDER	.02				
		TENTATIVE TO PROVIDER	.03				
		TENTATIVE TO PROGRAM	.50				
		TENTATIVE TO PROGRAM	.51				
		TENTATIVE TO PROGRAM	.52				
	SUBTOTAL		.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER	.01				
		SETTLEMENT TO PROGRAM	.02		69,085		453,966
7	TOTAL MEDICARE PROGRAM LIABILITY				3,342,053		2,208,721

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

PROVIDER NO: 14-1311	PERIOD: FROM 7/ 1/2008 TO 6/30/2009	PREPARED 12/ 8/2009
COMPONENT NO: 14-5552		WORKSHEET E-1

TITLE XVIII SNF

	DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	INPATIENT-PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			837,101		
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			9,965		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PRDVIDER	.01				
	ADJUSTMENTS TO PROVIDER	.02				
	ADJUSTMENTS TO PROVIDER	.03				
	ADJUSTMENTS TO PROVIDER	.04				
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50				
	ADJUSTMENTS TO PROGRAM	.51				
	ADJUSTMENTS TD PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL	.99		NONE		NONE
4	TOTAL INTERIM PAYMENTS			847,066		
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
	SUBTOTAL	.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01 SETTLEMENT TO PROGRAM .02				
7	TOTAL MEDICARE PROGRAM LIABILITY			847,066		

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHDRIZED PERSON: _____

DATE: ___/___/___

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(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THDUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 12/ 8/2009
14-1311	FROM 7/ 1/2008	WORKSHEET E-3
COMPONENT NO:	TO 6/30/2009	PART II
14-1311		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT

HOSPITAL

1	INPATIENT SERVICES	3,796,239
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	3,796,239
5	PRIMARY PAYER PAYMENTS	4,290
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	3,829,868
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	3,829,868
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	592,049
21	EXCESS REASONABLE COST	
22	SUBTOTAL	3,237,819
23	COINSURANCE	2,304
24	SUBTOTAL	3,235,515
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	106,538
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	106,538
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	93,145
26	SUBTOTAL	3,342,053
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVID ER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	3,342,053
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	3,411,138
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	-69,085
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO: 14-1311	PERIOD: FROM 7/ 1/2008	PREPARED 12/ 8/2009
COMPONENT NO: 14-5552	TO 6/30/2009	WORKSHEET E-3 PART III

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

TITLE XVIII SNF

		PPS TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
	COMPUTATION OF NET COST OF COVERED SERVICE		
1	INPATIENT HOSPITAL/SNF/NF SERVICES		
2	MEDICAL AND OTHER SERVICES		
3	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		
4	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)		
5	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		
6	SUBTOTAL		
7	INPATIENT PRIMARY PAYER PAYMENTS		
8	OUTPATIENT PRIMARY PAYER PAYMENTS		
9	SUBTOTAL		
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
10	ROUTINE SERVICE CHARGES		
11	ANCILLARY SERVICE CHARGES		
12	INTERNS AND RESIDENTS SERVICE CHARGES		
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE		
14	TEACHING PHYSICIANS		
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION		
16	TOTAL REASONABLE CHARGES		
	CUSTOMARY CHARGES		
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		
19	RATIO OF LINE 17 TO LINE 18		
20	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		
23	COST OF COVERED SERVICES		
	PROSPECTIVE PAYMENT AMOUNT		
24	OTHER THAN OUTLIER PAYMENTS		948,665
25	OUTLIER PAYMENTS		
26	PROGRAM CAPITAL PAYMENTS		
27	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS		
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		
30	SUBTOTAL		948,665
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)		
32	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE XVIII ENTER AMOUNT FROM LINE 30		948,665
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)		2,611
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
34	EXCESS OF REASONABLE COST		
35	SUBTOTAL		946,054
36	COINSURANCE		98,988
37	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19		
38	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
38.01	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING BEFORE 10/01/05 (SEE INSTRUCTIONS)		
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)		
39	UTILIZATION REVIEW		
40	SUBTOTAL (SEE INSTRUCTIONS)		847,066
41	INPATIENT ROUTINE SERVICE COST		
42	MEDICARE INPATIENT ROUTINE CHARGES		
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT OF PART A SERVICES		
45	RATIO OF LINE 43 TO 44		
46	TOTAL CUSTOMARY CHARGES		
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION		
50	OTHER ADJUSTMENTS (SPECIFY)		
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
52	SUBTOTAL		847,066
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)		
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS		
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER		847,066
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
57	INTERIM PAYMENTS		847,066
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:		PREPARED 12/ 8/2009
14-1311	FROM 7/ 1/2008		WORKSHEET E-3
COMPONENT NO:	TO 6/30/2009		PART III
14-5552			

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

	TITLE XVIII SNF	PPS TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
58	BALANCE DUE PROVIDER/PROGRAM		
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT ASSETS				
1	CASH ON HAND AND IN BANKS	2,393,773			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	8,126,048			
5	OTHER RECEIVABLES	352,707			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-3,312,042			
7	INVENTORY	325,633			
8	PREPAID EXPENSES	287,472			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	8,173,591			
	FIXED ASSETS				
12	LAND				
12.01					
13	LAND IMPROVEMENTS				
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	24,330,031			
14.01	LESS ACCUMULATED DEPRECIATION	-14,137,167			
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT				
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	10,192,864			
	OTHER ASSETS				
22	INVESTMENTS	7,660			
23	DEPOSITS ON LEASES	36,990			
24	DUE FROM OWNERS/OFFICERS	297,283			
25	OTHER ASSETS	310,969			
26	TOTAL OTHER ASSETS	652,902			
27	TOTAL ASSETS	19,019,357			

	LIABILITIES AND FUND BALANCE	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE	1,283,137			
29	SALARIES, WAGES & FEES PAYABLE	316,487			
30	PAYROLL TAXES PAYABLE				
31	NOTES AND LOANS PAYABLE (SHORT TERM)	1,780,702			
32	DEFERRED INCOME				
33	ACCELERATED PAYMENTS				
34	DUE TO OTHER FUNDS				
35	OTHER CURRENT LIABILITIES	481,184			
36	TOTAL CURRENT LIABILITIES	3,861,510			
	LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE	1,664,221			
38	NOTES PAYABLE				
39	UNSECURED LOANS				
40.01	LOANS PRIOR TO 7/1/66				
40.02	ON OR AFTER 7/1/66				
41	OTHER LONG TERM LIABILITIES				
42	TOTAL LONG-TERM LIABILITIES	1,664,221			
43	TOTAL LIABILITIES	5,525,731			
	CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE	13,493,626			
45	SPECIFIC PURPOSE FUND				
46	DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47	DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48	GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49	PLANT FUND BALANCE-INVESTED IN PLANT				
50	PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51	TOTAL FUND BALANCES	13,493,626			
52	TOTAL LIABILITIES AND FUND BALANCES	19,019,357			

STATEMENT OF CHANGES IN FUND BALANCES

I	PROVIDER NO:	I PERIOD:	I	PREPARED 12/ 8/2009
I	14-1311	I FROM 7/ 1/2008	I	WORKSHEET G-1
I		I TO 6/30/2009	I	

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	FUND BALANCE AT BEGINNING OF PERIOD		13,726,179		
2	NET INCOME (LOSS)		-655,906		
3	TOTAL		13,070,273		
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	ADDITIONS (CREDIT ADJUSTM	423,353			
5					
6					
7					
8					
9					
10	TOTAL ADDITIONS		423,353		
11	SUBTOTAL		13,493,626		
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12	DEDUCTIONS (DEBIT ADJUSTM				
13					
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		13,493,626		

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	FUND BALANCE AT BEGINNING OF PERIOD				
2	NET INCOME (LOSS)				
3	TOTAL				
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	ADDITIONS (CREDIT ADJUSTM				
5					
6					
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL				
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12	DEDUCTIONS (DEBIT ADJUSTM				
13					
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET				

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | PREPARED 12/ 8/2009 | WORKSHEET G-2 | PARTS I & II

PART I - PATIENT REVENUES

		REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
		GENERAL INPATIENT ROUTINE CARE SERVICES			
1	00	HOSPITAL	3,432,713		3,432,713
4	00	SWING BED - SNF			
5	00	SWING BED - NF			
6	00	SKILLED NURSING FACILITY	715,897		715,897
7	00	NURSING FACILITY	5,379,937		5,379,937
9	00	TOTAL GENERAL INPATIENT ROUTINE CARE	9,528,547		9,528,547
		INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10	00	INTENSIVE CARE UNIT	523,610		523,610
15	00	TOTAL INTENSIVE CARE TYPE INPAT HOSP	523,610		523,610
16	00	TOTAL INPATIENT ROUTINE CARE SERVICE	10,052,157		10,052,157
17	00	ANCILLARY SERVICES	10,942,077	30,025,332	40,967,409
18	00	OUTPATIENT SERVICES			
18	50	RURAL HEALTH CLINIC		1,368,066	1,368,066
19	00	HOME HEALTH AGENCY		658,321	658,321
24	00	PRO FEES	587,121	3,427,487	4,014,608
25	00	TOTAL PATIENT REVENUES	21,581,355	35,479,206	57,060,561

PART II-OPERATING EXPENSES

26	00	OPERATING EXPENSES		25,978,367
		ADD (SPECIFY)		
27	00	ADD (SPECIFY)		
28	00			
29	00			
30	00			
31	00			
32	00			
33	00	TOTAL ADDITIONS		
		DEDUCT (SPECIFY)		
34	00	DEDUCT (SPECIFY)	3,967,734	
35	00			
36	00			
37	00			
38	00			
39	00	TOTAL DEDUCTIONS		3,967,734
40	00	TOTAL OPERATING EXPENSES		22,010,633

STATEMENT OF REVENUES AND EXPENSES | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | PREPARED 12/ 8/2009 | WORKSHEET G-3

	DESCRIPTION	
1	TOTAL PATIENT REVENUES	57,060,561
2	LESS: ALLOWANCES AND DISCOUNTS ON	30,322,916
3	NET PATIENT REVENUES	26,737,645
4	LESS: TOTAL OPERATING EXPENSES	22,010,633
5	NET INCOME FROM SERVICE TO PATIENT	4,727,012
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS,FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER OPERATING REVENUE	216,997
24.10		
25	TOTAL OTHER INCOME	216,997
26	TOTAL	4,944,009
	OTHER EXPENSES	
27	WAYFAIR	5,379,937
28	NON-OPERATING REVENUE	219,978
29		
30	TOTAL OTHER EXPENSES	5,599,915
31	NET INCOME (OR LOSS) FOR THE PERIO	-655,906

HHA 1

		SALARIES	EMPLOYEE BENEFITS	TRANSPORTATION	CONTRACTED/ PURCHASED SVCS	OTHER COSTS	TOTAL
		1	2	3	4	5	6
	GENERAL SERVICE COST CENTERS						
1	CAP-REL COST-BLDG & FIX						
2	CAP-REL COST-MOV EQUIP						
3	PLANT OPER & MAINT						
4	TRANSPORTATION						
5	ADMIN & GENERAL	101,043				71,054	172,097
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	178,142					178,142
7	PHYSICAL THERAPY						
8	OCCUPATIONAL THERAPY						
9	SPEECH PATHOLOGY						
10	MEDICAL SOCIAL SERVICES						
11	HOME HEALTH AIDE						
12	SUPPLIES						
13	DRUGS						
13.20	COST ADMINISTERING DRUGS						
14	DME						
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SVCS						
16	RESPIRATORY THERAPY						
17	PRIVATE DUTY NURSING						
18	CLINIC						
19	HEALTH PROM ACTIVITIES						
20	DAY CARE PROGRAM						
21	HOME DEL MEALS PROGRAM						
22	HOMEMAKER SERVICE						
23	ALL OTHER						
23.50	TELEMEDICINE						
24	TOTAL (SUM OF LINES 1-23)	279,185				71,054	350,239

		RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION
		7	8	9	10
	GENERAL SERVICE COST CENTERS				
1	CAP-REL COST-BLDG & FIX				
2	CAP-REL COST-MOV EQUIP				
3	PLANT OPER & MAINT				
4	TRANSPORTATION				
5	ADMIN & GENERAL	-1,874	170,223		170,223
	HHA REIMBURSABLE SERVICES				
6	SKILLED NURSING CARE		178,142		178,142
7	PHYSICAL THERAPY				
8	OCCUPATIONAL THERAPY				
9	SPEECH PATHOLOGY				
10	MEDICAL SOCIAL SERVICES				
11	HOME HEALTH AIDE				
12	SUPPLIES				
13	DRUGS				
13.20	COST ADMINISTERING DRUGS				
14	DME				
	HHA NONREIMBURSABLE SERVICES				
15	HOME DIALYSIS AIDE SVCS				
16	RESPIRATORY THERAPY				
17	PRIVATE DUTY NURSING				
18	CLINIC				
19	HEALTH PROM ACTIVITIES				
20	DAY CARE PROGRAM				
21	HOME DEL MEALS PROGRAM				
22	HOMEMAKER SERVICE				
23	ALL OTHER				
23.50	TELEMEDICINE				
24	TOTAL (SUM OF LINES 1-23)	-1,874	348,365		348,365

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96 (05/2007)

COST ALLOCATION - HHA GENERAL SERVICE COST

PROVIDER NO:	PERIOD:	PREPARED 12/ 8/2009
14-1311	FROM 7/ 1/2008	WORKSHEET H-4
HHA NO:	TO 6/30/2009	PART I
14-7612		

HHA 1

		NET EXPENSES FOR COST ALLOCATION	CAP-REL COST-BLDG & FIX	CAP-REL COST-MOV EQUIP	PLANT OPER & MAINT	TRANSPORTATIO N	SUBTOTAL	ADMINISTRATIV E & GENERAL
		0	1	2	3	4	4A	5
	GENERAL SERVICE COST CENTERS							
1	CAP-REL COST-BLDG & FIX							
2	CAP-REL COST-MOV EQUIP							
3	PLANT OPER & MAINT							
4	TRANSPORTATION							
5	ADMINISTRATIVE & GENERAL	170,223					170,223	170,223
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE	178,142					178,142	170,223
7	PHYSICAL THERAPY							
8	OCCUPATIONAL THERAPY							
9	SPEECH PATHOLOGY							
10	MEDICAL SOCIAL SERVICES							
11	HOME HEALTH AIDE							
12	SUPPLIES							
13	DRUGS							
13.20	COST ADMINISTERING DRUGS							
14	DME							
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SVCS							
16	RESPIRATORY THERAPY							
17	PRIVATE DUTY NURSING							
18	CLINIC							
19	HEALTH PROM ACTIVITIES							
20	DAY CARE PROGRAM							
21	HOME DEL MEALS PROGRAM							
22	HOMEMAKER SERVICE							
23	ALL OTHERS							
23.50	TELEMEDICINE							
24	TOTAL (SUM OF LINES 1-23)	348,365					348,365	

		TOTAL
		6
	GENERAL SERVICE COST CENTERS	
1	CAP-REL COST-BLDG & FIX	
2	CAP-REL COST-MOV EQUIP	
3	PLANT OPER & MAINT	
4	TRANSPORTATION	
5	ADMINISTRATIVE & GENERAL	
	HHA REIMBURSABLE SERVICES	
6	SKILLED NURSING CARE	348,365
7	PHYSICAL THERAPY	
8	OCCUPATIONAL THERAPY	
9	SPEECH PATHOLOGY	
10	MEDICAL SOCIAL SERVICES	
11	HOME HEALTH AIDE	
12	SUPPLIES	
13	DRUGS	
13.20	COST ADMINISTERING DRUGS	
14	DME	
	HHA NONREIMBURSABLE SERVICES	
15	HOME DIALYSIS AIDE SVCS	
16	RESPIRATORY THERAPY	
17	PRIVATE DUTY NURSING	
18	CLINIC	
19	HEALTH PROM ACTIVITIES	
20	DAY CARE PROGRAM	
21	HOME DEL MEALS PROGRAM	
22	HOMEMAKER SERVICE	
23	ALL OTHERS	
23.50	TELEMEDICINE	
24	TOTAL (SUM OF LINES 1-23)	348,365

HHA 1

		CAP-REL COST-BLDG & FIX (SQUARE FEET) 1	CAP-REL COST-MOV EQUIP (DOLLAR VALUE) 2	PLANT OPER & MAINT (SQUARE FEET) 3	TRANSPORTATION (MILEAGE) 4	RECONCILIATION (5A	ADMINISTRATIVE & GENERAL (ACCUM. COST) 5
	GENERAL SERVICE COST CENTERS						
1	CAP-REL COST-BLDG & FIX						
2	CAP-REL COST-MOV EQUIP						
3	PLANT OPER & MAINT						
4	TRANSPORTATION						
5	ADMINISTRATIVE & GENERAL					-170,223	178,142
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE						178,142
7	PHYSICAL THERAPY						
8	OCCUPATIONAL THERAPY						
9	SPEECH PATHOLOGY						
10	MEDICAL SOCIAL SERVICES						
11	HOME HEALTH AIDE						
12	SUPPLIES						
13	DRUGS						
13.20	COST ADMINISTERING DRUGS						
14	DME						
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SVCS						
16	RESPIRATORY THERAPY						
17	PRIVATE DUTY NURSING						
18	CLINIC						
19	HEALTH PROM ACTIVITIES						
20	DAY CARE PROGRAM						
21	HOME DEL MEALS PROGRAM						
22	HOMEMAKER SERVICE						
23	ALL OTHERS						
23.50	TELEMEDICINE						
24	TOTAL (SUM OF LINES 1-23)					-170,223	178,142
25	COST TO BE ALLOCATED						170,223
26	UNIT COST MULIPLIER						.955547

HHA 1

	HHA COST CENTER	HHA TRIAL BALANCE (1) 0	NEW CAP REL COSTS-BLDG & 3	NEW CAP REL COSTS-MVBLE 4	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINISTRATIVE & GENERAL 6
1	ADMIN & GENERAL		15,414	10,799	70,520	96,733	19,687
2	SKILLED NURSING CARE	348,365				348,365	70,897
3	PHYSICAL THERAPY						
4	OCCUPATIONAL THERAPY						
5	SPEECH PATHOLOGY						
6	MEDICAL SOCIAL SERVICES						
7	HOME HEALTH AIDE						
8	SUPPLIES						
9	DRUGS						
9.20	COST ADMINISTERING DRUGS						
10	DME						
11	HOME DIALYSIS AIDE SVCS						
12	RESPIRATORY THERAPY						
13	PRIVATE DUTY NURSING						
14	CLINIC						
15	HEALTH PROM ACTIVITIES						
16	DAY CARE PROGRAM						
17	HOME DEL MEALS PROGRAM						
18	HOMEMAKER SERVICE						
19	ALL OTHER						
19.50	TELEMEDICINE						
20	TOTAL (SUM OF 1-19) (2)	348,365	15,414	10,799	70,520	445,098	90,584
21	UNIT COST MULIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

	HHA COST CENTER	MAINTENANCE & REPAIRS 7	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12
1	ADMIN & GENERAL	20,086	16,239		14,049		
2	SKILLED NURSING CARE						
3	PHYSICAL THERAPY						
4	OCCUPATIONAL THERAPY						
5	SPEECH PATHOLOGY						
6	MEDICAL SOCIAL SERVICES						
7	HOME HEALTH AIDE						
8	SUPPLIES						
9	DRUGS						
9.20	COST ADMINISTERING DRUGS						
10	DME						
11	HOME DIALYSIS AIDE SVCS						
12	RESPIRATORY THERAPY						
13	PRIVATE DUTY NURSING						
14	CLINIC						
15	HEALTH PROM ACTIVITIES						
16	DAY CARE PROGRAM						
17	HOME DEL MEALS PROGRAM						
18	HOMEMAKER SERVICE						
19	ALL OTHER						
19.50	TELEMEDICINE						
20	TOTAL (SUM OF 1-19) (2)	20,086	16,239		14,049		
21	UNIT COST MULIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA 1

	HHA COST CENTER	NURSING ADMINISTRATION 14	MEDICAL RECORDS & LIBRAR 17	SOCIAL SERVICE 18	SUBTOTAL 25	POST STEP DOWN ADJUST 26	SUBTOTAL 27
1	ADMIN & GENERAL				166,794		166,794
2	SKILLED NURSING CARE				419,262		419,262
3	PHYSICAL THERAPY						
4	OCCUPATIONAL THERAPY						
5	SPEECH PATHOLOGY						
6	MEDICAL SOCIAL SERVICES						
7	HOME HEALTH AIDE						
8	SUPPLIES						
9	DRUGS						
9.20	COST ADMINISTERING DRUGS						
10	DME						
11	HOME DIALYSIS AIDE SVCS						
12	RESPIRATORY THERAPY						
13	PRIVATE DUTY NURSING						
14	CLINIC						
15	HEALTH PROM ACTIVITIES						
16	DAY CARE PROGRAM						
17	HOME DEL MEALS PROGRAM						
18	HOMEMAKER SERVICE						
19	ALL OTHER						
19.50	TELEMEDICINE						
20	TOTAL (SUM OF 1-19) (2)				586,056		586,056
21	UNIT COST MULIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

	HHA COST CENTER	ALLOCATED HHA A & G 28	TOTAL HHA COSTS 29
1	ADMIN & GENERAL		
2	SKILLED NURSING CARE	166,794	586,056
3	PHYSICAL THERAPY		
4	OCCUPATIONAL THERAPY		
5	SPEECH PATHOLOGY		
6	MEDICAL SOCIAL SERVICES		
7	HOME HEALTH AIDE		
8	SUPPLIES		
9	DRUGS		
9.20	COST ADMINISTERING DRUGS		
10	DME		
11	HOME DIALYSIS AIDE SVCS		
12	RESPIRATORY THERAPY		
13	PRIVATE DUTY NURSING		
14	CLINIC		
15	HEALTH PROM ACTIVITIES		
16	DAY CARE PROGRAM		
17	HOME DEL MEALS PROGRAM		
18	HOMEMAKER SERVICE		
19	ALL OTHER		
19.50	TELEMEDICINE		
20	TOTAL (SUM OF 1-19) (2)	166,794	586,056
21	UNIT COST MULIPLIER	0.397828	

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

Health Financial Systems MCRIF32 | FOR FAIRFIELD MEMORIAL HOSPITAL | IN LIEU OF FORM CMS-2552-96 (05/2007)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
STATISTICAL BASIS

PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | PREPARED 12/ 8/2009
HHA NO: 14-7612 | WORKSHEET H-5 PART II

HHA 1

	HHA COST CENTER	NEW CAP REL COSTS-BLDG & (SQUARE FEET) 3	NEW CAP REL COSTS-MVBLE (SQUARE FEET) 4	EMPLOYEE BENEFITS (GROSS SALARIES) 5	RECONCILIATION 6A	ADMINISTRATIVE & GENERAL (ACCUM. COST) 6	MAINTENANCE & REPAIRS (SQUARE FEET) 7
1	ADMIN & GENERAL	1,920	1,920	279,185		96,733	1,920
2	SKILLED NURSING CARE					348,365	
3	PHYSICAL THERAPY						
4	OCCUPATIONAL THERAPY						
5	SPEECH PATHOLOGY						
6	MEDICAL SOCIAL SERVICES						
7	HOME HEALTH AIDE						
8	SUPPLIES						
9	DRUGS						
9.20	COST ADMINISTERING DRUGS						
10	DME						
11	HOME DIALYSIS AIDE SVCS						
12	RESPIRATORY THERAPY						
13	PRIVATE DUTY NURSING						
14	CLINIC						
15	HEALTH PROM ACTIVITIES						
16	DAY CARE PROGRAM						
17	HOME DEL MEALS PROGRAM						
18	HOMEMAKER SERVICE						
19	ALL OTHER						
19.50	TELEMEDICINE						
20	TOTAL (SUM OF 1-19)	1,920	1,920	279,185		445,098	1,920
21	COST TO BE ALLOCATED	15,414	10,799	70,520		90,584	20,086
22	UNIT COST MULIPLIER	8.028125	5.624479	0.252592		0.203515	10.461458

	HHA COST CENTER	OPERATION OF PLANT (SQUARE FEET) 8	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 9	HOUSEKEEPING (SQUARE FEET) 10	DIETARY (MEALS SERVED) 11	CAFETERIAS (PAID HOURS) 12	NURSING ADMINISTRATION (DIRECT NURSING HRS) 14
1	ADMIN & GENERAL	1,920		1,920			
2	SKILLED NURSING CARE						
3	PHYSICAL THERAPY						
4	OCCUPATIONAL THERAPY						
5	SPEECH PATHOLOGY						
6	MEDICAL SOCIAL SERVICES						
7	HOME HEALTH AIDE						
8	SUPPLIES						
9	DRUGS						
9.20	COST ADMINISTERING DRUGS						
10	DME						
11	HOME DIALYSIS AIDE SVCS						
12	RESPIRATORY THERAPY						
13	PRIVATE DUTY NURSING						
14	CLINIC						
15	HEALTH PROM ACTIVITIES						
16	DAY CARE PROGRAM						
17	HOME DEL MEALS PROGRAM						
18	HOMEMAKER SERVICE						
19	ALL OTHER						
19.50	TELEMEDICINE						
20	TOTAL (SUM OF 1-19)	1,920		1,920			
21	COST TO BE ALLOCATED	16,239		14,049			
22	UNIT COST MULIPLIER	8.457813		7.317188			

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

PROVIDER NO:	PERIOD:	PREPARED 12/ 8/2009
14-1311	FROM 7/ 1/2008	WORKSHEET H-5
HHA NO:	TO 6/30/2009	PART II
14-7612		

HHA 1

HHA COST CENTER	MEDICAL RECORDS & LIBRARY (GROSS REV) 17	SOCIAL SERVICE (TIME SPENT) 18
1 ADMIN & GENERAL		
2 SKILLED NURSING CARE		
3 PHYSICAL THERAPY		
4 OCCUPATIONAL THERAPY		
5 SPEECH PATHOLOGY		
6 MEDICAL SOCIAL SERVICES		
7 HOME HEALTH AIDE		
8 SUPPLIES		
9 DRUGS		
9.20 COST ADMINISTERING DRUGS		
10 DME		
11 HOME DIALYSIS AIDE SVCS		
12 RESPIRATORY THERAPY		
13 PRIVATE DUTY NURSING		
14 CLINIC		
15 HEALTH PROM ACTIVITIES		
16 DAY CARE PROGRAM		
17 HOME DEL MEALS PROGRAM		
18 HOMEMAKER SERVICE		
19 ALL OTHER		
19.50 TELEMEDICINE		
20 TOTAL (SUM OF 1-19)		
21 COST TO BE ALLOCATED		
22 UNIT COST MULIPLIER		

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMDRIAL HOSPITAL IN LIEU OF FORM CMS-2552-96 (05/2008)
APPORTIONMENT OF PATIENT SERVICE COSTS | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | PREPARED 12/ 8/2009 | WORKSHEET H-6 | PARTS I II & III | HHA 1

[ ] TITLE V [X] TITLE XVIII [ ] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:
COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

	COST PER VISIT COMPUTATION PATIENT SERVICES	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	PROGRAM VISITS PART A
			1	2	3	4	5	6
1	SKILLED NURSING	2	586,056		586,056	3,877	151.16	1,054
2	PHYSICAL THERAPY	3				928		460
3	OCCUPATIONAL THERAPY	4				142		62
4	SPEECH PATHOLOGY	5				31		11
5	MEDICAL SOCIAL SERVICES	6						
6	HOME HEALTH AIDE SERVICE	7				61		7
7	TOTAL		586,056		586,056	5,039		1,594

		-----PROGRAM VISITS----- PART B		----------COST OF SERVICES-------- PART B			
		NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	PART A	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	TOTAL PROGRAM COST
		7	8	9	10	11	12
1	SKILLED NURSING	1,931		159,323	291,890		451,213
2	PHYSICAL THERAPY	332					
3	OCCUPATIONAL THERAPY	38					
4	SPEECH PATHOLOGY	9					
5	MEDICAL SOCIAL SERVICES						
6	HOME HEALTH AIDE SERVICES	9					
7	TOTAL	2,319		159,323	291,890		451,213

	LIMITATION COST COMPUTATION PATIENT SERVICES					PROGRAM COST LIMITS	PROGRAM VISITS PART A
		1	2	3	4	5	6
8	SKILLED NURSING	9914					
9	PHYSICAL THERAPY	9914					
10	OCCUPATIONAL THERAPY	9914					
11	SPEECH PATHOLOGY	9914					
12	MEDICAL SOCIAL SERVICES	9914					
13	HOME HEALTH AIDE SERVICE	9914					
14	TOTAL						

		-----PROGRAM VISITS----- PART B		----------COST OF SERVICES-------- PART B			
		NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	PART A	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	TOTAL PROGRAM COST
		7	8	9	10	11	12
8	SKILLED NURSING						
9	PHYSICAL THERAPY						
10	OCCUPATIONAL THERAPY						
11	SPEECH PATHOLOGY						
12	MEDICAL SOCIAL SERVICES						
13	HOME HEALTH AIDE SERVICE						
14	TOTAL						

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96 (05/2008)
APPORTIONMENT OF PATIENT SERVICE COSTS

	PROVIDER NO:	PERIOD:		PREPARED 12/ 8/2009
	14-1311	FROM 7/ 1/2008		WORKSHEET H-6
	HHA NO:	TO 6/30/2009		PARTS I II & III
	14-7612			HHA 1

[ ] TITLE V [X] TITLE XVIII [ ] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:
COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

	SUPPLIES AND EQUIPMENT COST COMPUTATION / OTHER PATIENT SERVICES	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS	TOTAL CHARGES	RATIO	PROGRAM COVERED CHARGES PART A
			1	2	3	4	5	6
15	COST OF MEDICAL SUPPLIES	8.00				18,771		5,145
16	COST OF DRUGS	9.00						
16.20	COST OF DRUGS	9.20						

		PROGRAM COVERED CHARGES --PART B-- NOT SUBJECT TO DEDUCT & COINSUR	PROGRAM COVERED CHARGES --PART B-- SUBJECT TO DEDUCT & COINSUR	COST OF SERVICES PART A	COST OF SERVICES --PART B-- NOT SUBJECT TO DEDUCT & COINSUR	COST OF SERVICES --PART B-- SUBJECT TO DEDUCT & COINSUR
		7	8	9	10	11
15	COST OF MEDICAL SUPPLIES	13,626				
16	COST OF DRUGS					
16.20	COST OF DRUGS					

	PER BENEFICIARY COST LIMITATION:	MSA NUMBER	AMOUNT
		1	2
162	PROGRAM UNDUP CENSUS FROM WRKST S-4	9914	
17	PER BENE COST LIMITATION (FRM FI)	9914	
18	PER BENE COST LIMITATION (LN 17*18)		

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		FROM WKST C PT I, COL 9	COST TO CHARGE RATIO	TOTAL HHA CHARGES	HHA SHARED ANCILLARY COSTS	TRANSFER TO PART I AS INDICATED
			1	2	3	4
1	PHYSICAL THERAPY	50	.471579			COL 2, LN 2
2	OCCUPATIONAL THERAPY	51				COL 2, LN 3
3	SPEECH PATHOLOGY	52				COL 2, LN 4
4	MEDICAL SUPPLIES CHARGED TO PATIENT	55	.238650			COL 2, LN 15
5	DRUGS CHARGED TO PATIENTS	56	.315361			COL 2, LN 16

PART III - OUTPATIENT THERAPY REDUCTION COMPUATION

		FROM PART I, COL 5	PART B SERVICES SUBJECT TO DEDUCTIBLES AND COINSURANCE: COST PER VISIT	PROGRAM VISITS PRIOR 1/1/1998	PROGRAM VISITS 1/1/1998 TO 12/31/1998	PROGRAM COSTS PRIOR 1/1/1998	PROGRAM COSTS 1/1/1998 TO 12/31/1998	PROG VISITS ON OR AFTER 1/1/1999
		1	2	2.01	3	3.01	4	5
1	PHYSICAL THERAPY	2						
2	OCCUPATIONAL THERAPY	3						
3	SPEECH PATHOLOGY	4						
4	TOTAL (SUM OF LINES 1-3)							

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOO:	PREPARED 12/ 8/2009
14-1311	FROM 7/ 1/2008	WORKSHEET H-7
HHA NO:	TO 6/30/2009	PARTS I & II
14-7612		

TITLE XVIII HHA 1

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

		PART A	PART B NOT SUBJECT TO DED & COINS	PART B SUBJECT TO OED & COINS
		1	2	3
1	REASONABLE COST OF SERVICES			
2	TOTAL CHARGES	193,917	301,513	
	CUSTOMARY CHARGES			
3	AMOUNT ACTUALLY COLLECTEO FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
4	AMOUNT THAT WOULO HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAO SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(B)			
5	RATIO OF LINE 3 TO 4 (NOT TO EXCEEO 1.000000)			
6	TOTAL CUSTOMARY CHARGES	193,917	301,513	
7	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST	193,917	301,513	
8	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
9	PRIMARY PAYOR AMOUNTS			

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		PART A SERVICES 1	PART B SERVICES 2
10	TOTAL REASONABLE COST		
10.01	TOTAL PPS REIMBURSEMENT-FULL EPISODES WITHOUT OUTLIERS	234,174	233,862
10.02	TOTAL PPS REIMBURSEMENT-FULL EPISODES WITH OUTLIERS		28,501
10.03	TOTAL PPS REIMBURSEMENT-LUPA EPISODES	198	1,229
10.04	TOTAL PPS REIMBURSEMENT-PEP EPISODES	1,604	
10.05	TOTAL PPS REIMBURSEMENT-SCIC WITHIN A PEP EPISOOE		
10.06	TOTAL PPS REIMBURSEMENT-SCIC EPISODES		
10.07	TOTAL PPS OUTLIER REIMBURSEMENT-FULL EPISODES WITH OUTLIERS		9,588
10.08	TOTAL PPS OUTLIER REIMBURSEMENT-PEP EPISOOES		
10.09	TOTAL PPS OUTLIER REIMBURSEMENT-SCIC WITHIN A PEP EPISODE		
10.10	TOTAL PPS OUTLIER REIMBURSEMENT-SCIC EPISOOES		
10.11	TOTAL OTHER PAYMENTS		
10.12	DME PAYMENTS		
10.13	OXYGEN PAYMENTS		
10.14	PROSTHETIC AND ORTHOTIC PAYMENTS		
11	PART B OEOUCTIBLES BILLED TO MEOICARE PATIENTS (EXCLUDE COINSURANCE)		
12	SUBTOTAL	235,976	273,180
13	EXCESS REASONABLE COST		
14	SUBTOTAL	235,976	273,180
15	COINSURANCE BILLEO TO PROGRAM PATIENTS		
16	NET COST	235,976	273,180
17	REIMBURSABLE BAO OEBTS		
17.01	REIMBURSABLE BAD OEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL COSTS - CURRENT COST REPORTING PERIOO	235,976	273,180
19	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM OISPOSITION OF DEPRECIABLE ASSETS		
20	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM AGENCIES' TERMINATION OR DECREASE IN MEOICARE UTILIZATION		
21	OTHER ADJUSTMENTS (SPECIFY)		
22	SUBTOTAL	235,976	273,180
23	SEQUESTRATION AOJUSTMENT		
24	SUBTOTAL	235,976	273,180
25	INTERIM PAYMENTS	235,976	273,180
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEOIARY USE ONLY)		
26	BALANCE DUE PROVIDER/PROGRAM		
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II SECTION 115.2		

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96 (11/1998)

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2008 TO 6/30/2009 | PREPARED 12/ 8/2009 WORKSHEET H-8

HHA NO: 14-7612

TITLE XVIII HHA 1

	DESCRIPTION		PART A MM/DD/YYYY 1	PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			235,976		273,180
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PROVIDER	.01				
	ADJUSTMENTS TO PROVIDER	.02				
	ADJUSTMENTS TO PROVIDER	.03				
	ADJUSTMENTS TO PROVIDER	.04				
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50				
	ADJUSTMENTS TO PROGRAM	.51				
	ADJUSTMENTS TO PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL	.99		NONE		NONE
4	TOTAL INTERIM PAYMENTS			235,976		273,180
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
	SUBTOTAL	.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01 SETTLEMENT TO PROGRAM .02				
7	TOTAL MEDICARE PROGRAM LIABILITY			235,976		273,180

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

---

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

	PROVIDER NO:	PERIOD:	
	14-1311	FROM 7/ 1/2008	PREPARED 12/ 8/2009
	COMPONENT NO:	TO 6/30/2009	WORKSHEET M-1
	14-8500		

RHC 1

		COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI-CATION 4
	FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN	330,254		330,254	
2	PHYSICIAN ASSISTANT				
3	NURSE PRACTITIONER	63,844		63,844	
4	VISITING NURSE				
5	OTHER NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	LABORATORY TECHNICIAN				
9	OTHER FACILITY HEALTH CARE STAFF COSTS				
10	SUBTOTAL (SUM OF LINES 1-9)	394,098		394,098	
	COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT				
12	PHYSICIAN SUPERVISION UNDER AGREEMENT				
13	OTHER COSTS UNDER AGREEMENT				
14	SUBTOTAL (SUM OF LINES 11-13)				
	OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES				
16	TRANSPORTATION (HEALTH CARE STAFF)				
17	DEPRECIATION-MEDICAL EQUIPMENT				
18	PROFESSIONAL LIABILITY INSURANCE				
19	OTHER HEALTH CARE COSTS				
20	ALLOWABLE GME COSTS				
21	SUBTOTAL (SUM OF LINES 15-20)				
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	394,098		394,098	
	COSTS OTHER THAN RHC/FQHC SERVICES				
23	PHARMACY				
24	DENTAL				
25	OPTOMETRY				
26	ALL OTHER NONREIMBURSABLE COSTS				
27	NONALLOWABLE GME COSTS				
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
	FACILITY OVERHEAD				
29	FACILITY COSTS				
30	ADMINISTRATIVE COSTS	88,895	97,271	186,166	-4,877
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	88,895	97,271	186,166	-4,877
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	482,993	97,271	580,264	-4,877

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009 I PREPARED 12/ 8/2009 I WORKSHEET M-1

I COMPONENT NO: 14-8500 I

RHC 1

		RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
	FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN	330,254		330,254
2	PHYSICIAN ASSISTANT			
3	NURSE PRACTITIONER	63,844		63,844
4	VISITING NURSE			
5	OTHER NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
9	OTHER FACILITY HEALTH CARE STAFF COSTS			
10	SUBTOTAL (SUM OF LINES 1-9)	394,098		394,098
	COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT			
12	PHYSICIAN SUPERVISION UNDER AGREEMENT			
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)			
	OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES			
16	TRANSPORTATION (HEALTH CARE STAFF)			
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE			
19	OTHER HEALTH CARE COSTS			
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)			
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	394,098		394,098
	COSTS OTHER THAN RHC/FQHC SERVICES			
23	PHARMACY			
24	DENTAL			
25	OPTOMETRY			
26	ALL OTHER NONREIMBURSABLE COSTS			
27	NONALLOWABLE GME COSTS			
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
	FACILITY OVERHEAD			
29	FACILITY COSTS			
30	ADMINISTRATIVE COSTS	181,289		181,289
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	181,289		181,289
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	575,387		575,387

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED
14-1311	FROM 7/ 1/2008	12/ 8/2009
COMPONENT NO:	TO 6/30/2009	WORKSHEET M-2
14-8500		

RHC 1

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
	POSITIONS				
1	PHYSICIANS	1.03	2,887	1,400	1,442
2	PHYSICIAN ASSISTANTS			700	
3	NURSE PRACTITIONERS	.50	1,847	700	350
4	SUBTOTAL (SUM OF LINES 1-3)	1.53	4,734		1,792
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.53	4,734		
9	PHYSICIAN SERVICES UNDER AGREEMENTS				
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	394,098			
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)				
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	394,098			
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000			
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	181,289			
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	331,595			
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	512,884			
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)				
18	SUBTRACT LINE 17 FROM LINE 16	512,884			
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	512,884			
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	906,982			

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

	PROVIDER NO:	PERIOD:	PREPARED 12/ 8/2009
	14-1311	FROM 7/ 1/2008	WORKSHEET M-2
	COMPONENT NO:	TO 6/30/2009	
	14-8500		

RHC 1

VISITS AND PRODUCTIVITY

		GREATER OF COL. 2 OR COL. 4
		5
	POSITIONS	
1	PHYSICIANS	
2	PHYSICIAN ASSISTANTS	
3	NURSE PRACTITIONERS	
4	SUBTOTAL (SUM OF LINES 1-3)	4,734
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	4,734
9	PHYSICIAN SERVICES UNDER AGREEMENTS	

(1) THE PRODUCTIVITY STANDARD FOR PHYSICIANS IS 4,200 AND 2,100 FOR ALL OTHERS. IF AN EXCEPTION TO THE STANDARD HAS BEEN GRANTED (WORKSHEET S-8, LINE 13 EQUALS "Y"), COLUMN 3, LINES 1 THRU 3 OF THIS WORKSHEET SHOULD BE BLANK. THIS APPLIES TO RHC ONLY.

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

I	PROVIDER NO:	I PERIOD:		I PREPARED 12/ 8/2009
I	14-1311	I FROM 7/ 1/2008	I	WORKSHEET M-3
I	COMPONENT NO:	I TO 6/30/2009	I	
I	14-8500	I	I	

TITLE XVIII RHC 1

	DETERMINATION OF RATE FOR RHC/FQHC SERVICES	
1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	906,982
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	906,982
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	4,734
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	4,734
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	191.59

CALCULATION OF LIMIT (1)

		PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	999.00	999.00
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	191.59	191.59
	CALCULATION OF SETTLEMENT		
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		1,443
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		276,464
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)		
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)		
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)		
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*		276,464
16.01	PRIMARY PAYER AMOUNT		
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		8,382
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		268,082
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		214,466
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		214,466
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23	OTHER ADJUSTMENTS (SPECIFY)		
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		214,466
25	INTERIM PAYMENTS		144,520
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		69,946
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDER YEAR PROVIDERS USE COLUMN 2 ONLY.

* FOR LINE 15, USE COLUMN 2 ONLY FOR GRADUATE MEDICAL EDUCATION PASS THROUGH COST.

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES
[X] RHC [ ] FQHC

PROVIDER NO: 14-1311
COMPONENT NO: 14-8500
PERIOD: FROM 7/ 1/2008 TO 6/30/2009
PREPARED 12/ 8/2009
WORKSHEET M-5

RHC 1

	DESCRIPTION		PART B MM/DD/YYYY 1	AMOUNT 2
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			144,520
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	ADJUSTMENTS TO PROVIDER	.01		
	ADJUSTMENTS TO PROVIDER	.02		
	ADJUSTMENTS TO PROVIDER	.03		
	ADJUSTMENTS TO PROVIDER	.04		
	ADJUSTMENTS TO PROVIDER	.05		
	ADJUSTMENTS TO PROGRAM	.50		
	ADJUSTMENTS TO PROGRAM	.51		
	ADJUSTMENTS TO PROGRAM	.52		
	ADJUSTMENTS TO PROGRAM	.53		
	ADJUSTMENTS TO PROGRAM	.54		
	SUBTOTAL	.99		NONE
4	TOTAL INTERIM PAYMENTS			144,520
	TO BE COMPLETED BY INTERMEDIARY			
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	TENTATIVE TO PROVIDER	.01		
	TENTATIVE TO PROVIDER	.02		
	TENTATIVE TO PROVIDER	.03		
	TENTATIVE TO PROGRAM	.50		
	TENTATIVE TO PROGRAM	.51		
	TENTATIVE TO PROGRAM	.52		
	SUBTOTAL	.99		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01		69,946
		SETTLEMENT TO PROGRAM .02		
7	TOTAL MEDICARE PROGRAM LIABILITY			214,466

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.